CHAPTER

8

Immigration and Social Services

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Introduction

The impact of immigration on social services in the United States is commonly discussed in fiscal terms: What proportion of the cost of social programs is attributable to the participation of immigrants in those programs? Most of the Federal social programs that serve immigrants are administered by the Department of Health and Human Services (DHHS), the Social Security Administration (SSA), and the U.S. Department of Agriculture (USDA). They include mainstream programs such as Medicaid, Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), food stamps, and programs targeted at special populations, such as migrant farmworkers or recently arrived refugees. The program descriptions in this chapter were contributed by the departments responsible for them. The descriptions include any provisions that encouraged or limited participation by immigrants during the time periods covered. The program descriptions pertain to a time period before the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, which made major changes in immigrant eligibility for those programs.

Many of the programs were designed to provide income support for needy persons or to alleviate poverty in other ways. Programs that provide direct benefits to individuals or households usually have eligibility criteria that disqualify persons who are not present legally in the United States. Many of these programs compile data on the immigration status or country of birth of their service populations, making it possible to estimate the cost of benefits paid to noncitizens or to foreign-born persons. Other programs provide a more general range of social services and have not maintained records on the immigration status of persons benefiting from the services.

The 1990 Census contains information regarding the eligibility for, and participation of, foreign-born persons, both citizens and noncitizens, in some social service programs. Census data are available on the sources of household income, including public assistance payments. The Census also provides information on income levels and the prevalence of poverty among foreign-born persons, which provides a measure of eligibility for income-support programs and a context for the program information. That information is summarized here. Table 1 presents several measures of the income of the foreign-born population. For comparison, similar data are displayed for the total U.S. population.

The incomes of foreign-born persons differ greatly by two related measures that may serve as indicators of assimilation: length of time in the United States and citizenship status. For this reason, the tabulations emphasize the contrasts within the foreign-born population. Part of the contrast has to do with age; the median age in 1990 of the foreign-born citizens and of persons who arrived before 1980 was nearly 47 years, while the median age of noncitizens was 32.2 and of persons who arrived during the 1980's was 29.2. The observed income differences, in part, reflect these age differences.

Income Levels

The per capita income of the foreign-born population that entered before 1980 was $19,423, more than twice that of persons who arrived during the 1980's and substantially higher than the $14,420 per capita income of the total U.S. population. The contrast is not as great for the median household and family incomes, but the earlier-arriving foreign-born households still maintain an advantage over those who arrived later and a slight advantage over the total population. Immigrants who are not citizens, and especially those who arrived in the 1980's, have particularly low incomes relative to other residents.

Household income distributions give an impression consistent with the average income levels. Looking at households whose income in 1989 was less than $5,000, only 5.7 percent of households headed by a person who immigrated before 1980 fell into this category, compared with 6.2 percent of all U.S. households and 10.5 percent of households headed by more recent arrivals. At the upper end of the income distribution, 12.2 percent of households headed by a person who arrived before 1980 had incomes in 1989 of $75,000 or more,

compared with 9.5 percent of all U.S. households and 6.6 percent of households headed by recent immigrants. The analysis by citizenship status gives similar results.

Poverty Status

In 1989, according to Census figures, 13.1 percent of persons living in the United States, and 10 percent of families, had incomes below the poverty level. (Poverty status is determined through a combination of income, family size, and composition.) Persons who immigrated before 1980 were less likely to be impoverished than the general population (12 percent), but families headed by such persons had a slightly higher poverty rate (11 percent). Immigrants and their families who arrived in the 1980's had poverty rates more than double the national average. Again, the analysis by citizenship status yields similar results, except that foreign-born citizens as individuals and as families are less likely to be in poverty than the population as a whole.

Public Assistance Income

The tabulation of sources of household income according to four categories (earnings, social security, public assistance, and retirement income) helps to describe past and present economic activity by different types of households, including their receipt of income transfer payments from social programs. Households headed by foreign-born persons who arrived before 1980 are slightly less likely to have earnings from current wages and more likely to be receiving social security payments than all U.S. households. This and their receipt of retirement income in addition to social security reflects their age structure, with a median age 14 years above that of the general population. These households receive public assistance at a rate slightly higher than that of the general population, 8.9 percent compared with 7.5 percent.

The median age of persons who immigrated during the 1980's is only 3.7 years younger than that of the overall U.S. population, at 29.2, but the income structure of the households they head is in sharp contrast to that of earlier immigrants and the general population. These households are more likely to have earned income and very unlikely to receive social security or retirement income. Despite their earned income, they are also slightly more likely to receive public assistance, at a rate of 9.7 percent. They are slightly less likely than the U.S. population as a whole to have the family structure associated with a propensity to use public assistance: the female householder with no husband present and with children under 18 years of age. Again, the findings by citizenship status are similar to those by period of arrival, except that the income profile of households headed by noncitizens is more consistent with that of an older population with many retired persons.

One possible measure of the impact of immigration on social service programs is the amount of benefits paid to immigrants. In the 1990 Census, households headed by foreign-born persons reported public assistance income in 1989 of $3.679 billion in the aggregate. Of this amount, $2.254 billion was paid to households headed by noncitizens. Such income includes payments from the AFDC program, general assistance payments, and SSI payments, but it does not include payments for medical services or the value of food stamps received by the household.

The use of public assistance at these levels by recent immigrants is somewhat unexpected, given the restrictions at the time on access to public assistance by most persons during their first 3 to 5 years in the United States. An analysis of patterns of use of public assistance by immigrants who arrived during the 1980's based on the 1990 census provides some insight into how this situation can occur. The findings are summarized in Table 2.

TABLE 1.—Characteristics of Foreign-Born Persons and All Persons in 1990 Census, by Time of Entry and Citizenship

Characteristics	Foreign-Born Population		Total U.S. Population
	Entered 1980's	Entered Pre 1980	
Income/Poverty Measures			
Per capita income	$9,408	$19,423	**$14,420**
Median household[1] income	$24,136	$30,553	**$30,056**
Median family[1] income	$24,493	$35,733	**$35,225**
Households with income (%):			
Less than $5,000	10.5%	5.7%	**6.2%**
$75,000 or more	6.6%	12.2%	**9.5%**
Income below poverty level (%):			
Persons	26.3%	12.0%	**13.1%**
Families	23.4%	11.0%	**10.0%**
Households with (%):			
Earnings	89.4%	78.5%	**80.3%**
Social Security income	4.2%	29.0%	**26.3%**
Public assistance income	9.7%	8.9%	**7.5%**
Retirement income	2.5%	13.6%	**15.6%**
Demographic Measures			
Median age (years)	28.3	46.5	**32.9**
Female householder, no husband present, with own child(ren) under 18 years (% of families):	9.1%	7.4%	**9.3%**

Source: Calculated by INS from U.S. Census Bureau, *Census of Population and Housing, 1990; SSTF 1.*

[1] A "foreign-born household" is defined as one in which the householder is a foreign-born person, so a foreign-born household or family may contain one or more native-born persons.

TABLE 1.—Characteristics of Foreign-Born Persons and All Persons in 1990 Census, by Time of Entry and Citizenship (continued)

Characteristics	Foreign-Born Population		Total U.S. Population
	Non-citizens	Citizens	
Income/Poverty Measures			
Per capita income	$11,293	$20,538	**$14,420**
Median household[1] income	$25,503	$31,046	**$30,056**
Median family[1] income	$26,518	$37,340	**$35,225**
Households with income (%):			
Less than $5,000	9.0%	5.2%	**6.2%**
$75,000 or more	7.4%	13.5%	**9.5%**
Income below poverty level (%):			
Persons	23.3%	10.8%	**13.1%**
Families	20.7%	8.7%	**10.0%**
Households with (%):			
Earnings	87.6%	76.0%	**80.3%**
Social Security income	10.0%	32.8%	**26.3%**
Public assistance income	10.6%	7.7%	**7.5%**
Retirement income	4.8%	15.6%	**15.6%**
Demographic Measures			
Median age (years)	32.2	46.9	**32.9**
Female householder, no husband present, with own child(ren) under 18 years (% of families):	9.6%	6.1%	**9.3%**

Source: Calculated by INS from U.S. Census Bureau, *Census of Population and Housing, 1990; SSTF 1.*

[1] A "foreign-born household" is defined as one in which the householder is a foreign-born person, so a foreign-born household or family may contain one or more native-born persons.

The 1990 Census data available for this analysis separate the immigrants who arrived during the 1980's into four arrival periods of approximately 2 or 3 years each. Table 2 shows that most of the immigrant households receiving public assistance, 68.1 percent, are headed by persons who arrived before 1980. The percentage of each arrival cohort receiving public assistance does not vary greatly from the overall average of 9.1 percent. The immigrants who arrived in 1980 and 1981 are most likely to receive public assistance, at a level of 11.7 percent. Of the households who arrived in the 1987-1990 period, 8.5 percent received public assistance. These levels of use of public assistance alleviate only part of the poverty among the foreign-born population. Table 2 shows that about one-third of those who arrived in the 1987-1990 period were classified as being in poverty. This proportion dropped for those with longer periods of residence, to a level comparable with that of the total U.S. population, as noted above.

A substantial minority of the householders who arrived during the 1980's and were receiving public assistance are likely to have arrived as refugees, who are exempt from the bar on receiving assistance soon after arrival in the United States. (The census does not ascertain the immigration status of noncitizens, so refugee status is inferred if the householder was born in a country from which most immigrants in the 1980's were first admitted in refugee status. These countries are Cambodia, Cuba, Laos, the Soviet Union, and Vietnam.) More than 45 percent of the foreign-born householders who arrived in the 1987-1990 period or the 1980-1981 period and were receiving public assistance were from these refugee-producing countries. That figure was about 31 percent for similar persons who arrived in the mid-1980's and 15 percent for those who arrived before 1980. Because refugees are admitted for humanitarian reasons and are not required to meet the usual criterion of self-support before being allowed to enter, their reliance on public assistance programs in the early years should not be unexpected.

TABLE 2.—Receipt of Public Assistance Income by Arrival Cohorts of Foreign-Born Households in the 1990 Census

		Arrival Period				
Item	**Total**	**1987-90**	**1985-86**	**1982-84**	**1980-81**	**pre-1980**
Foreign-born households[1] (thousands)	**7,746.5**	593.3	453.2	571.2	699.2	5,429.5
Number with public assistance income (thousands)	**706.0**	50.4	37.0	55.7	82.0	480.9
Percent with public assistance income	**9.1%**	8.5%	8.2%	9.8%	11.7%	8.9%
Percent of recipient households from refugee[2] countries	**23.0%**	45.4%	31.2%	31.5%	45.6%	15.2%
Income below the poverty level, percent of:						
Persons	**18.2%**	34.3%	24.0%	20.2%	21.1%	12.0%
Families	**14.9%**	31.7%	22.1%	19.7%	21.1%	11.0%

Source: Calculated by INS from U.S. Census Bureau, *Census of Population and Housing, 1990; SSTF 1.*

[1]A "foreign-born household" is defined as one in which the householder is a foreign-born person, so a foreign-born household or family may contain one or more native-born persons. The arrival period is that of the householder.
[2]Refugee countries are those from which most immigrants since 1980 were first admitted in refugee status.

Other points should be considered in interpreting these data. Because a foreign-born household is defined as one in which the head of the household is a foreign-born person, such a household may contain a mix of foreign- and native-born persons. A household may include more than one family unit, and if any subfamily within it receives public assistance, the entire household will be classified as having public assistance income. In a complex household, it is entirely possible for some members to be eligible for and receiving such assistance while others are not. These data impart an upward bias to the measurement of "households receiving public assistance."

U.S. Department of Health and Human Services

Summary of Immigration's Impact on HHS Programs

HHS is responsible for providing or financing a wide range of health and social services to individuals residing within the United States. Before passage of PRWORA on August 22, 1996, immigrants were generally eligible for many of these services. Except in a limited number of programs (for example, AFDC and Medicaid), eligibility for most health and social services funded by this department was based primarily on an individual's need for such services regardless of immigrant status. Therefore, reliable data that would allow determination of immigration's impact on HHS administered programs were not ordinarily collected. For example, community health centers provide preventive and primary health care to anyone in need of such services. Because these centers are located in areas that contain medically underserved and disadvantaged populations, they undoubtedly also serve immigrants. However, because receipt of center services has never been based on an individual's immigrant status, the centers do not record or retain information regarding the number of immigrants served. Nevertheless, by providing adequate care, including immunizations, these centers play a significant role in ensuring the health of immigrant communities, as well as maintaining the overall public health.

With the significant exceptions of AFDC, Medicaid, and Medicare, most HHS programs are "closed ended" appropriations. Therefore, in most programs the number of immigrants served has no effect on overall spending levels, which are fixed. Use of services by additional immigrants would generally have no budget impact.

HHS has four notable organizational components that provide services to both citizens and immigrants: the Administration for Children and Families (ACF), the Public Health Service (PHS) agencies, the Administration on Aging (AoA) and the Health Care Financing Administration (HCFA). ACF funds a vast array of programs that provide numerous health and social services. For example, Head Start provides comprehensive educational, health, social, nutritional, and other services to low-income, preschool-age children and their families. The Office of Refugee Resettlement (ORR) and AFDC are two of the major programs administered by ACF and have particular relevance to immigrants.

ORR provides cash, medical assistance, social services, and care for unaccompanied minors to persons who have been admitted into the United States as refugees, political asylees, and Cuban and Haitian entrants. In FY1994, ORR's expenditures for cash and medical assistance totaled approximately $191.4 million. According to a 1994 survey of recent refugees, entrants, and Amerasian immigrants conducted by ORR, almost one-third of refugee households were self-supporting. Conversely, slightly more than one-third of such households completely depended on public assistance. Other findings concluded that employment increases with length of U.S. residence and use of public assistance by refugees declines as they enter the paid labor force.

Unlike most other HHS programs, eligibility for AFDC, which was the major cash welfare program for low-income families with children before the enactment of PRWORA, is conditional based on legal immigrant status. Undocumented, or illegal, immigrants were not eligible for these welfare benefits. Similarly, sponsored legal immigrants had their eligibility determined by counting some portion of their sponsors' income and resources as being available to them in a procedure known as "sponsor-to-alien deeming." According to administrative data, or "quality control" data, the welfare recipiency rate for legal immigrants was 5.8 percent of all AFDC recipients in 1994. In addition, according to the 1995 General Accounting Office (GAO) report *Welfare Reform: Implications of Proposals on Legal Immigrants' Benefits*, most households that receive AFDC and include immigrant recipients also include citizen recipients.

ACF also provides services to immigrants through a variety of block grants and programs. Among other ACF programs that are relevant to immigrants are the Community Services Block Grant (CSBG), which funds community-based entities such as migrant and seasonal farm-worker organizations and the Social Services Block Grant (SSBG), which funds a variety of social service activities. With the enactment of PRWORA, States have been given the option of denying SSBG services to certain categories of immigrants. As mentioned above, most of ACF's programs do not gather and maintain specific information on immigrant use of their services, but it is reasonable to assume that immigrants, in addition to citizens, benefit from these services.

Among the agencies that comprise the PHS, three major agencies provide services to immigrants, as well as citizens: the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA). With the exception of the Refugee Mental Health Program and the Refugee Health Assessment Program, eligibility for the other services funded by these PHS organizations is not conditional based on an individual's immigrant status. Accordingly, there is little program information on the use of these services by immigrants, although it is reasonable to assume that immigrants, like citizens, benefit from these services. SAMHSA administers several mental health programs, as well as block grants and demonstration programs, which fund or provide substance abuse and mental health services. CDC funds State and local health departments that provide services, such as various preventive health activities, to individuals. The only criteria for receipt of CDC benefits is the need for health care. The programs supported by HRSA target underserved and disadvantaged populations and fund organizations that provide preventive and primary health care to children and families. Similarly, the only requirement for receiving these services is the need for health care.

AoA is the Federal focal point and advocacy agency for older persons. It works with a nationwide network of offices and agencies to coordinate and develop systems of services for older persons and their caregivers. Among the services its programs provide are: access services, in-home care, community services, and care-giver services. Eligibility for AoA programs and services is not conditional based on immigration status.

HCFA reimburses providers for health services provided to eligible individuals through the Medicare and Medicaid programs. Medicare is a Federal health insurance program for most people age 65 or older and certain people with disabilities. In 1994, Medicare provided more than 38 million individuals with access to health services. Medicare eligibility is based solely on age or disability and past contributions to the Medicare trust fund. HCFA has not collected information regarding citizenship or immigrant status of Medicare recipients because it is generally not relevant to program eligibility or participation. Any individual who does not meet the contribution requirement for Medicare, but does meet the age or disability requirements, may purchase Medicare coverage at an actuarially determined price. Legal immigrants must also satisfy a 5-year residency requirement before being eligible to purchase Medicare coverage. Finally, to the extent Medicare is financed through Medicare tax and premium payments, the payroll taxes paid by younger, first-generation immigrants help support retirees under this system.

Medicaid is a Federal- and State-financed entitlement program that purchases medical assistance for certain low-income families and persons who are aged, blind, or have a disability. Similar to AFDC, eligibility for Medicaid benefits is conditional based on legal immigrant status. Undocumented immigrants are not eligible for Medicaid benefits, except for emergency services. But legal immigrants who otherwise meet the Medicaid eligibility requirements are eligible on the same basis as citizens. In 1994, an estimated 35.1 million individuals were enrolled in Medicaid. However, the Federal Government has never required States to submit data regarding the number of legal immigrants enrolled. Therefore, HCFA administrative data can not provide us with reliable estimates of the number of immigrants receiving Medicaid. However, the Urban Institute, under contract with HHS, used Medicaid Quality Control data in conjunction with Social Security Administration data to estimate the number of immigrants receiving Medicaid in 1994. They estimated that 3.2 million immigrants were enrolled in Medicaid, representing 7.5 percent of the total caseload. According to the 1996 Current Population Survey, immigrants represent 12.6 percent of the population under poverty and so the proportion of immigrants using Medicaid in 1994, when there were no restrictions on access by legal immigrants, was smaller than might be expected.

HHS provides or funds a wide array of social and health services to promote the public health and well being of millions of individuals and families residing in the United States. HHS programs have been crucial in improving the overall quality of life of families and communities over the last several decades. Many HHS programs and services have been available to children, families, the elderly, and the disabled who have been in need of various types of assistance without regard to their citizenship or immigrant status. Because of the lack of quantitative data on program participation of immigrants or the demand for services among this population, it is difficult to determine immigration's impact on HHS programs and services over the past 7 years. However, as indicated above, and based on the limited data available, immigrants do not appear to substantially affect HHS program spending levels.

The enactment of welfare reform on August 22, 1996, significantly changed the status of legal immigrants and their eligibility for certain major assistance programs. For the first time legal immigrants will be treated much differently than citizens when it comes to eligibility for assistance under certain cash, health, and social services programs. For example, most legal immigrants will be ineligible for the Food Stamp Program (FSP), which is administered by the USDA, solely because of their immigrant status. The need for nutritional assistance is no longer sufficient for Federal assistance.

In addition, AFDC, which was once a joint Federal and State cash entitlement program for low-income children and families administered by HHS, is now being transformed into a capped block grant program providing funds to States, which now have the flexibility to determine how assistance will be provided for, and to which, needy families. This new block grant program is called Temporary Assistance for Needy Families (TANF). The new welfare law allows States to determine whether or not to provide TANF assistance to most legal immigrants, known as qualified aliens. States also have the option to determine if qualified aliens are eligible for services under the Medicaid program and the SSBG program. Although aliens already receiving assistance on August 22, 1996, continue to be eligible for assistance until January 1, 1997, States have the authority to deny assistance under these three programs to most qualified aliens after January 1, 1997.

Under PRWORA, most immigrants arriving after August 22, 1996 are banned from receiving "Federal Means-Tested Public Benefits" for their first five years in the United States. This ban does not apply to Refugees, Asylees, aliens whose deportation is being withheld, Amerasians, Cuban/Haitian entrants, Veterans, and members of the military on active duty, their spouses and unmarried dependent children. On August 26, 1997, HHS published a notice in the Federal Register interpreting the term "Federal Means-Tested Benefit" which stated that Medicaid and TANF were the only HHS programs providing such benefits. Subsequently the Children's Health Insurance Program (CHIP) was created by Congress and it was determined to also constitute a "Federal Means-Tested Benefit."

PRWORA also denies "Federal Public Benefits"[1] to non-qualified aliens, primarily undocumented aliens and non-immigrants (e.g., students, tourists, etc.), and requires that agencies providing such benefits implement procedures to verify the citizenship and immigration status of all applicants. On August 4, 1998, HHS published a notice in the Federal Register interpreting the term "Federal Public Benefit" which stated that 31 HHS programs provide such benefits and therefore must verify the citizenship and immigration status of

[1] The HHS programs which provide "Federal Public Benefits" according to the August 4, 1998 interpretation are: Adoption Assistance, Administration on Developmental Disabilities (ADD) – State Developmental Disabilities, Councils (direct services only), ADD – Special Projects (direct services only), ADD – University Affiliated Programs (clinical disability assessment services only), Adult Programs/Payment to Territories, Agency for Health Care Policy and Research Dissertation Grants, Child Care and Development Fund, Clinical Training Grant for Faculty Development in Alcohol & Drug Abuse, Foster Care, Health Profession Education and Training Assistance, Independent Living Program, Job Opportunities for Low Income Individuals (JOLI), Low Income Home Energy Assistance Program (LIHEAP), Medicare, Medicaid (except assistance for an emergency medical condition), Mental Health Clinical Training Grants, Native Hawaiian Loan Program, Refugee Cash Assistance, Refugee Medical Assistance, Refugee Preventive Health Services Program, Refugee Social Services Formula and Discretionary Program, Refugee Targeted Assistance Formula and Discretionary Program, Refugee Unaccompanied Minors Program, Refugee Voluntary Agency Matching Grant Program, Repatriation Program, Residential Energy Assistance Challenge Option (REACH), Social Services Block Grant (SSBG), State Child Health Insurance Program (CHIP), and Temporary Assistance for Needy Families (TANF).

applicants in order to deny benefits to non-qualified aliens. HHS is currently reviewing the public comments on this notice and will subsequently issue a final notice of interpretation.

These new rules that ban most noncitizens from certain Federal assistance programs and allow States to deny other forms of assistance to individuals based solely on their immigrant status represent a significant change in the way legal immigrants have been treated. According to the aforementioned GAO report, quantifying how immigrants will be affected by welfare reform will be difficult, especially because these policy changes may have some effect on immigrants' behavior. Because the law was just enacted, it is too early to determine what those effects may be on immigrants' behavior, and what impacts it will have on HHS programs. Therefore, no attempt to provide statistical estimates will be made at this time. While the effect of these changes on programs is unclear and the number of immigrants that will be affected cannot be quantified precisely, these changes should have a significant impact on needy immigrants, including children, elderly, and the disabled.

The Urban Institute is conducting a study, funded by HHS, INS, and the Department of Agriculture, which will gather information on the health and economic status of immigrants, their families, and their communities in New York City and Los Angeles. It is also designed to gather — to the extent possible — information on the effects of welfare reform on immigrants and their communities. The study consists of several parts: (1) 1650 household interviews in each city, with in-depth follow-ups of 150 households in each city; (2) interviews with community organizations (both governmental and non-governmental); and (3) analyses of several existing data sets (e.g., CPS, NHIS, etc.), including administrative data sets. These data and analyses are intended to provide an accurate profile of immigrants and their communities in order to make valid comparisons with citizens, and to identify relevant trends and indicators with respect to immigrants and their communities.

Administration for Children and Families

Office of Refugee Resettlement

The Federal Government, through ORR, funds and administers programs for persons who have been admitted into the United States with refugee status, for those who have been granted political asylum, and for Cuban and Haitian entrants. (Refugees, asylees, and entrants are collectively called refugees in the subsequent program descriptions.) The primary objective of these programs is to help refugees become self-sufficient as quickly as possible after their arrival in the United States. Because refugees, by definition, are legal residents, their use of benefits and services, as described below, will have an impact on Federal social service programs.

Agency Summary

Federal resettlement assistance to refugees is provided primarily through a State-administered refugee resettlement program. States are responsible for planning, administering, and coordinating refugee resettlement activities. Services and activities available to refugees include cash and medical assistance, social services, and care of unaccompanied minors. More detailed information on ORR programs appears in the Report to the Congress on the Refugee Resettlement Program, which is published annually.

Cash and Medical Assistance

Many working-age refugees from all parts of the world are able to find employment soon after arrival in their new communities. For those who need services before placement in jobs, short-term financial support may be available through the local resettlement agency. However, when refugees require additional time, assistance, and training beyond short-term support, they may apply for help from the State-administered cash and medical assistance programs, which are supported with Federal funds.

Refugees are eligible to apply for cash assistance benefits under Title IV-A of the Social Security Act or the SSI programs and may participate as long as they continue to meet program eligibility requirements. Refugees who qualify for AFDC or SSI also become eligible for Medicaid benefits. Refugees also may be eligible for the Medicaid medically needy program if they have incomes slightly above that required for AFDC and SSI eligibility and incur medical expenses that bring their net income down to the State Medicaid eligibility level.

The Refugee Act of 1980, as codified in the Immigration and Nationality Act (INA), permits ORR to reimburse States for Title IV-A payments made to refugees, for Medicaid costs incurred on a refugee's behalf, and for refugee SSI costs in those States that supplement Federal SSI payments. This reimbursement period, originally limited to 36 months, was reduced to 31 months in 1986, 24 months in 1988, and 4 months in 1990. Since 1990, ORR appropriations have not been sufficient to continue reimbursing States for these costs.

Some refugees do not qualify for cash assistance under the Title IV-A or SSI programs because they do not meet the categorical eligibility criteria. These refugees may receive special cash assistance called Refugee Cash Assistance (RCA), which is provided at the same level as AFDC. As with the previously programs, the original period of eligibility was limited to 36 months after entry into the United States. The period of eligibility was reduced to 18 months in FY1982, 12 months in FY1989, and 8 months in FY1992. The RCA eligibility period has remained stable at 8 months.

In all States, refugees eligible for RCA are also eligible for Refugee Medical Assistance (RMA) for the same period as RCA. Refugees also may be eligible for RMA alone if they have incomes slightly above that required for cash assistance eligibility and incur medical expenses that bring their net income down to the Medicaid eligibility level. States are reimbursed for RMA costs.

After the period of eligibility for RCA and RMA has expired, refugees who continue to be ineligible for Title IV-A, SSI, or Medicaid may qualify for State- or locally-funded General Assistance (GA) programs on the same basis as other residents of the locality in which they reside. Similarly, refugees not eligible for Medicaid or no longer eligible for RMA may be eligible for State- or locally-funded General Medical Assistance (GMA) programs. The Federal Government previously reimbursed States for their GA and GMA costs for a period of months after entry into the United States but, since 1990, appropriations have not been sufficient to allow ORR to provide such reimbursement.

In FY 1994, the cash and medical assistance expenditures were approximately $191.4 million. Table 3 provides information on funds appropriated for ORR programs, refugee admissions, time-eligible populations, and period of eligibility for FY 1981 through FY 1995.

TABLE 3.—Refugee Appropriations, Admissions, Time-Eligible Population, and Period of Eligibility (Months): FYs1981 to 1995

Fiscal Year	Appropriation (dollars)	Admissions Actual[1]	36-Month Population[2]	AFDC/SSI Medicaid[3]	RCA RMA[3]	GA GMA[3]
1981	901,652,000	159,252	477,731	1-36	1-36	0
1982	689,747,000	97,355	474,003	1-36	1-18	19-36
1983	585,000,000	60,036	316,898	1-36	1-18	19-36
1984	541,761,000	70,601	228,966	1-36	1-18	19-36
1985	444,372,000	67,167	200,203	1-36	1-18	19-36
1986	315,812,000	60,544	198,322	1-31	1-18	19-31
1987	339,597,000	58,857	186,578	1-31	1-18	19-31
1988	346,933,000	76,919	196,330	1-31	1-18	19-31
1989	382,356,000	106,886	242,662	1-24	1-12	13-24
1990	389,758,000	122,939	306,744	1-4	1-12	0
1991	410,623,000	113,989	343,814	0	1-12	0
1992	410,630,000	131,767	368,695	0	1-8	0
1993	381,481,000	119,084	364,840	0	1-8	0
1994	389,218,000	112,136	362,987	0	1-8	0
1995	413,786,000	110,000	341,220	0	1-8	0

[1] Includes Amerasians and their accompanying family members; entry for FY1994 is the admission ceiling
[2] Refugees and Amerasians residing in the United States 36 months or less
[3] Months of ORR reimbursement after arrival in the United States
[4] Admissions and 36-month population for FY1995 are estimates based on FY1995 admission ceiling

Unaccompanied Minors

Resettlement of unaccompanied minor refugees who require foster care upon their arrival in the United States is provided through two national voluntary agencies, the United States Catholic Conference (USCC) and the Lutheran Immigration and Refugee Service (LIRS). These agencies place the refugee children in licensed child welfare programs operated by their local affiliates.

Unaccompanied minor refugees are eligible for the same general range of child welfare benefits available to nonrefugee children in the State. They are placed in home foster care, group care, independent living, or residential treatment. States receive Federal reimbursement for costs incurred on their behalf until the month after the l8th birthday or such higher age as is permitted under the State's child welfare plan (Title IV-B of the Social Security Act).

Social Services

Federal funding is available to States for a broad range of social services to refugees. Currently, about 85 percent of the social service funds are allocated directly to States according to their proportion of all refugees who arrived in the United States during the 3 previous fiscal years. States with small refugee populations receive at least $75,000 in social service funds.

States use most of their social service funds for employment-related services, such as English language training, employment counseling, job placement, and vocational training. States may also provide services identified in a State's program under Title XX of the Social Security Act and certain services listed in ORR policy instructions to States, such as orientation, translation, social adjustment, transportation, and daycare.

Discretionary Projects

The remaining social service funds are used for a variety of initiatives and individual projects intended to contribute to the effectiveness and efficiency of refugee resettlement service delivery. During FYs1991-1994, major discretionary projects included the following:

- A special initiative that targets refugees in five States and two California counties with high refugee welfare dependency rates or large numbers of refugees on welfare. ORR provides financial support to enable the States to implement individualized plans to change the service delivery system to increase employment and reduce welfare dependency among targeted populations in selected communities.
- The Microenterprise Development Initiative assists refugees in starting or expanding small businesses through training in business skills, access to credit, and individualized business technical assistance.
- The Planned Secondary Resettlement program helps unemployed refugees relocate from areas of high welfare dependency to communities with favorable employment prospects.
- The Preferred Communities program assists national voluntary agencies to defray the costs associated with resettling arriving refugees in communities with good job opportunities and with reducing the number of refugees placed in high-impact sites.
- Grants for specialized services are awarded to the almost 71,000 Amerasian youths and their accompanying family members who have arrived in the United States since 1988.
- The Community and Family Strengthening program supports services to strengthen communities and families. These grants offer increased services to women, crime prevention services for refugee youth, parent-child literacy, in-home counseling services for spousal and child abuse, services to victims of domestic violence, and the establishment of local community centers.
- The Unanticipated Arrivals program enables communities to respond to the arrival of new ethnic populations of refugees and entrants, particularly where the existing services systems do not have appropriate bilingual capacity or cannot respond adequately because available funds have already been obligated.

Targeted Assistance

This program provides employment services to refugees and entrants who reside in counties with unusually large concentrations of refugees and entrants and a high use of public assistance. The substantial need of these populations for services has necessitated supplementation of local service resources.

In addition to the county-targeted assistance program, Florida has received funds to provide health care to eligible Cuban/Haitian entrants and to the Dade County public school system to support education for entrant children.

Voluntary Agency Matching Grant Program

This program provides an alternative to the federally funded, State-administered programs. Federal funds of up to $1,000 per refugee are available, on a dollar-for-dollar matching basis, to voluntary agencies participating in the program. The goal is to help refugees attain self-sufficiency within 4 months after arrival. Matching grants fund a range of activities, including case management, employment services, maintenance assistance, and support services, such as English language training and health services.

Because of significant increases in the numbers of arriving Jewish refugees from the former Soviet Union who are traditionally served by this program, matching grant appropriations have increased substantially in recent years, from $5.8 million in FY1987 to $32.6 million in FY1994.

Refugee Preventive Health

Refugees often have health problems resulting from poor living conditions and a lack of medical care in their countries of origin or during their flight and wait for resettlement. Health care services are available to refugees in first-asylum camps, refugee processing centers, and after a refugee's arrival in the United States.

Medical and other volunteers treat refugee health problems and work to improve the general health conditions in refugee camps. Public health advisors from CDC are stationed in Southeast Asia and Europe to monitor the quality of health screening for U.S.-bound refugees. At U.S. ports-of-entry, refugees and their medical records are inspected by PHS Quarantine Officers who also notify the appropriate State and local health departments of the refugees' arrival.

The medical problems of refugees, while not necessarily constituting a public health hazard, might adversely affect their successful resettlement and employment. CDC awards grants to State and local health agencies to medically screen and identify health problems of newly arriving refugees that might impair their effective resettlement, employability, and eventual self-sufficiency and to refer refugees with such problems for treatment.

Impact of Immigration on ORR Programs

Although a person may meet the criteria for admission into the United States as a refugee, the existence of the U.S. refugee admissions program does not automatically entitle that individual to enter the United States. The annual admissions program is a legal mechanism for admitting an applicant who is among those persons for whom the United States has a special concern and otherwise is eligible. The need for resettlement, not the desire of a refugee to enter the United States, is a governing principle in the management of the U.S. refugee program.

Refugees arrive through a highly regulated process. Although crisis events that increase the flow of refugees may be unpredictable, refugees are admitted to the United States through a procedure that balances foreign policy considerations against perceived domestic concerns, such as unemployment and housing shortages. The refugee resettlement process is considerably more controlled than the arrival of immigrants, who have outnumbered refugee arrivals in recent years by a magnitude of seven or eight to one, because a high proportion of immigrants are immediate relatives of U.S. citizens and not regulated by the immigration quota system.

From FYs1992-1994, the United States admitted approximately 394,979 refugees, Amerasian immigrants and Cuban/Haitian entrants, compared with 343,831 in the previous 3-year period (FYs1989-1991). These persons came from more than 30 countries, with the largest number arriving from the republics of the former Soviet Union. In FY 1994, about 43,125 Soviet refugees arrived, down by about one-third from the peak year of FY 1992 (61,018), but far above the low of 743 refugee arrivals in FY 1986.

In FY1994, Vietnamese arrivals (including Amerasian immigrants) decreased to about 36,995 from 42,500 the year before. Also declining significantly were arrivals from Ethiopia whose nearly 297 arrivals in FY1994 were only one-tenth of the annual arrivals in the early 1990's. Similarly, Iranian arrivals in FY1994 (859) measured only one-eighth of the peak of 6,624 in FY1987.

Offsetting these declines are significant gains from other countries. From FYs1983-1991, Somalian, Sudanese, and Liberian arrivals together numbered 277. During the latest 3-year period (FYs1992-1994), refugees from these African nations soared to 11,555. Iraqi arrivals rose 13-fold to 13,000 from the previous 3-year period (FYs1989-1991). Arrivals from the republics of the former Yugoslavia rose to approximately 7,400 in FY1994, compared with only 3 in FY1992.

The largest increase in arrivals were recorded from the Caribbean region. Haitian arrivals, primarily entrants, soared to 17,500, compared with only 1 in the previous 3-year period (FYs1989-1991). Cuban arrivals, also primarily entrants, doubled to over 29,000 during the past 3 years (FYs1992-1994).

Because of these developments, the trend in refugee arrivals has been upward during the 3-year period from FYs1992-1994. However, the FY1994 arrivals of 126,475 are low compared with the peak year of 1980, when 166,727 refugees arrived. Table 4 illustrates the trends in admissions from different parts of the world from FYs1983-1995.

Refugees arriving in the United States are placed in all 50 States, the District of Columbia, and several territories. The placement process manages to spread the impact of refugees around the country. Refugees are generally not placed in a location that already has a high refugee population unless they have a close relative residing in the area. Because most recent refugees have been joining relatives who became established earlier, their distribution still does not parallel that of the overall U.S. population.

Table 5 shows the number of refugees and Amerasian immigrants resettled in each State during FY1994 and Table 6 shows the initial resettlement of Cuban and Haitian entrants from FYs1992-1995. From FYs1992-1994, California received 23 percent of all new arrivals, and New York ranked second with 18 percent. From FYs1989-1991, these two States received 28 percent and 17 percent of arrivals, respectively. Also in the earlier period, Florida received 5 percent of all arrivals. From FYs1992-1994, its numbers soared to almost 40,250, and its proportion doubled to 10 percent of all arrivals. Arrivals to Florida rose sharply again in FY1995 to more than 30,700, almost 23 percent of all arrivals to the United States.

The nationality composition of the refugee population arriving in each State varies considerably, depending, in part, on the residence patterns established by earlier refugees and immigrants. While most States have received a majority of Southeast Asians recently, some States have received mostly refugees from other countries. The example of the Cuban refugees in Florida is well known. New York, California, and Illinois receive many Soviet and Eastern European refugees; Michigan receives large numbers of refugees from Eastern Europe and the Near East, and several small States have received a predominance of refugees from one or two countries.

TABLE 4.—Refugee, Entrant, and Amerasian Arrivals by Country of Citizenship: FYs1983-1995

Country	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	83-95
Afghanistan	2,790	2,021	2,200	2,418	3,161	2,211	1,741	1,595	1,443	1,465	1,234	24	13	**22,316**
Albania	56	42	44	82	47	74	42	104	1,339	1,168	397	159	49	**3,603**
Bulgaria	137	129	125	151	108	149	105	345	563	102	23	26	6	**1,969**
Cambodia	13,041	19,727	19,175	9,845	1,786	2,897	2,162	2,328	179	162	61	15	6	**71,384**
Cuba	617	87	180	143	292	3,365	4,170	4,706	4,188	6,654	6,870	15,468	37,037	**83,777**
Czechoslovakia	1,227	822	948	1,427	1,031	661	910	331	153	16	1	3	0	**7,530**
Ethiopia	2,544	2,517	1,739	1,265	1,800	1,447	1,723	3,144	4,085	2,927	2,710	297	192	**26,360**
Haiti	0	0	0	0	0	4	1	0	0	10,440	1,945	5,043	2,551	**19,984**
Hungary	644	544	520	653	664	771	1,054	259	12	2	0	1	0	**5,124**
Iran	902	2,862	3,421	3,203	6,624	6,235	4,835	3,100	2,650	1,964	1,155	859	973	**38,783**
Iraq	1,583	161	232	305	196	40	103	66	822	3,375	4,560	4,930	3,475	**19,848**
Laos	2,907	7,218	5,195	12,313	13,394	14,597	12,560	8,715	9,232	7,285	6,945	6,211	3,682	**110,254**
Liberia	0	0	0	0	0	4	1	0	1	620	946	590	55	**2,217**
Libya	0	0	5	1	2	2	1	1	344	1	0	0	0	**357**
Nicaragua	0	0	0	0	36	201	341	634	194	18	60	13	13	**1,510**
Poland	5,508	4,300	2,822	3,577	3,406	3,308	3,576	1,629	371	165	52	43	23	**28,780**
Romania	3,741	4,293	4,456	2,588	2,999	2,833	3,276	4,071	4,533	1,510	230	81	32	**34,643**
Somalia	0	1	0	0	2	6	45	17	119	1,528	2,695	3,508	2,526	**10,447**
Sudan	4	0	3	0	2	1	6	59	6	126	253	1,289	1,694	**3,443**
USSR	1,371	730	647	793	3,458	20,020	39,387	49,742	38,496	61,018	48,354	43,125	35,509	**342,650**
Vietnam[1]	22,819	24,856	25,222	21,703	19,661	17,571	21,924	27,796	28,385	26,856	31,405	34,107	32,250	**334,555**
Amerasian[2]	0	0	0	0	3	363	8,720	13,916	16,580	17,140	11,220	2,888	948	**71,778**
Yugoslavia	10	25	22	2	2	2	3	2	1	3	1,877	7,418	9,872	**19,239**
Zaire	11	31	30	11	9	7	20	70	39	63	199	83	115	**688**
Other[3]	124	235	181	77	179	152	200	339	251	350	354	294	283	**3,019**
Total	**60,036**	**70,601**	**67,167**	**60,557**	**58,862**	**76,921**	**106,906**	**122,939**	**113,986**	**144,958**	**123,546**	**126,475**	**131,304**	**1,264,258**

[1] Refugees only; Amerasians and accompanying family members listed separately
[2] Thirteen Amerasians listed their country of citizenship as Cambodia in 1991, and another eight Amerasians listed their country of citizenship as Cambodia in 1992. All 21 were assigned to the category of Amerasian.
[3] Includes countries with fewer than 100 arrivals in any year

TABLE 5.—Refugee, Entrant, and Amerasian Arrivals by Country of Citizenship and State of Initial Resettlement: FY1994

State	Amer.[1]	Vietnam	Laos	Cuba[2]	Haiti[2]	Iran	Iraq	Ethiopia	Liberia	Somalia	Sudan	USSR[3]	Yugo.[4]	Total
Alabama	54	35	0	3	63	0	0	0	0	0	0	31	8	**194**
Alaska	6	31	0	0	0	0	0	0	0	0	0	20	15	**72**
Arizona	117	336	0	127	53	12	146	3	0	36	4	157	281	**1,284**
Arkansas	0	95	0	1	0	0	0	0	0	0	0	3	7	**106**
California	358	13,611	3,140	386	79	496	866	80	9	845	91	6,950	638	**27,629**
Colorado	25	402	29	4	55	4	12	0	0	30	28	539	70	**1,202**
Conn.	62	190	0	63	106	0	34	2	0	0	2	508	98	**1,091**
Delaware	0	5	0	0	2	0	0	0	0	0	0	26	9	**42**
Dist. Col.	95	286	0	4	32	15	102	18	18	63	1	0	14	**693**
Florida	106	760	0	11,207	1,954	11	66	5	0	4	10	574	338	**15,080**
Georgia	164	1,875	11	49	9	8	39	6	29	308	20	485	336	**3,349**
Hawaii	14	265	0	0	0	0	2	0	0	0	0	2	0	**283**
Idaho	5	96	0	11	44	0	41	0	0	0	0	67	93	**373**
Illinois	74	580	5	45	53	14	401	13	10	50	24	2,180	932	**4,456**
Indiana	0	68	0	6	28	2	28	5	0	0	0	138	55	**360**
Iowa	74	342	3	0	9	0	41	2	0	11	157	34	246	**932**
Kansas	15	401	10	1	6	2	21	0	2	28	2	123	25	**636**
Kentucky	84	226	0	15	22	6	82	0	0	34	0	138	195	**804**
Louisiana	85	520	3	55	35	0	0	0	0	0	0	6	28	**734**
Maine	11	0	0	0	0	19	11	2	0	67	44	25	24	**204**
Maryland	35	400	0	30	135	15	33	2	82	67	30	948	54	**1,837**
Massach.	11	996	45	23	211	2	97	2	26	174	0	1,565	191	**3,373**
Michigan	64	368	208	9	153	26	978	0	19	29	0	693	248	**2,822**
Minnesota	17	550	1,060	12	37	0	21	19	59	140	15	593	107	**2,656**
Mississippi	0	50	0	8	7	0	0	0	0	0	0	0	0	**65**
Missouri	115	430	0	85	206	8	217	6	10	59	39	326	360	**1,872**
Montana	2	3	1	0	0	0	0	0	1	0	0	28	6	**41**
Nebraska	24	364	0	0	3	0	85	0	0	0	0	82	35	**593**
Nevada	0	23	0	346	0	0	6	5	0	12	31	4	39	**469**
New Hamp.	4	202	0	0	0	2	1	0	0	0	0	13	23	**252**
New Jersey	33	345	0	523	421	4	50	5	44	10	3	982	155	**2,599**
New Mexico	7	100	0	496	0	0	38	0	0	0	0	20	4	**666**
New York	128	618	1	241	409	107	207	9	60	137	111	18,080	927	**21,139**

TABLE 5.—Refugee, Entrant, and Amerasian Arrivals by Country of Citizenship and State of Initial Resettlement: FY1994 (continued)

State	Amer.[1]	Vietnam	Laos	Cuba[2]	Haiti[2]	Iran	Iraq	Ethiopia	Liberia	Somalia	Sudan	USSR[3]	Yugo.[4]	Total
N. Carolina	112	343	30	9	12	5	5	3	6	59	15	69	111	**785**
N. Dakota	41	28	0	0	61	0	69	0	0	2	14	35	124	**375**
Ohio	15	190	40	7	2	7	85	2	7	2	0	1,222	80	**1,666**
Oklahoma	13	359	0	2	0	2	5	0	12	0	0	0	7	**409**
Oregon	22	830	9	20	45	4	28	4	0	50	3	848	80	**1,962**
Penn.	107	475	8	89	215	2	232	19	67	38	12	2,073	221	**3,570**
R.I.	0	15	41	0	0	0	7	0	53	0	0	142	1	**260**
S. Carolina	9	113	0	0	0	0	9	0	0	0	0	37	9	**177**
S. Dakota	3	8	0	0	0	0	13	6	0	0	197	38	21	**286**
Tenneesee	100	273	0	0	159	17	183	10	8	148	74	106	102	**1,196**
Texas	382	3,647	23	416	120	52	286	47	27	206	294	262	432	**6,223**
Utah	46	242	0	0	0	0	44	0	0	24	40	123	98	**620**
Vermont	64	73	0	0	0	0	18	0	0	0	0	10	110	**275**
Virginia	68	833	0	7	94	13	59	4	34	593	22	219	139	**2,096**
Wash.	110	2,084	106	33	134	4	262	18	0	247	6	2,255	263	**5,547**
W. Virginia	6	2	0	0	0	0	0	0	7	0	0	0	1	**17**
Wis.	1	22	1,438	3	0	0	0	0	0	35	0	361	58	**1,921**
Other[5]	0	0	0	98	0	0	0	0	0	0	0	0	0	**98**
Total	**2,888**	**34,110**	**6,211**	**14,434**	**4,974**	**859**	**4,930**	**297**	**590**	**3,508**	**1,289**	**43,140**	**7,418**	**125,391**

[1] This tabulation includes infants born in the Refugee Processing Center in the Philippines who have been granted Amerasian status retroactively by legislation enacted November 5, 1990.
[2] Includes entrants
[3] Includes refugees from the republics of the former Soviet Union, primarily from Russia
[4] Includes refugees from the republics of the former Yugoslavia, primarily from Bosnia-Herzegovina
[5] Includes territories and unknown States

TABLE 6.—Cuban and Haitian Entrant Arrivals by State of Initial Resettlement: FYs1992-1995 [1]

State	Cuba					Haiti				
	1992	1993	1994	1995	92-95	1992	1993	1994	1995	92-95
Alabama	0	1	4	49	**54**	18	0	0	9	**27**
Alaska	0	0	0	0	**0**	0	0	0	0	**0**
Arizona	29	12	117	280	**438**	1	0	1	7	**9**
Arkansas	0	0	1	4	**5**	0	0	0	0	**0**
California	137	78	263	613	**1,091**	218	0	2	1	**221**
Colorado	0	0	3	9	**12**	0	0	0	0	**0**
Connecticut	0	2	53	151	**206**	68	2	5	3	**78**
Delaware	0	0	0	2	**2**	9	3	0	0	**12**
District of Columbia	2	0	0	10	**12**	1	0	0	0	**1**
Florida	2,183	3,198	10,488	25,222	**41,091**	8,397	567	1,419	659	**11,042**
Georgia	5	2	39	152	**198**	40	0	0	0	**40**
Hawaii	0	0	0	0	**0**	0	0	0	0	**0**
Idaho	1	3	0	1	**5**	0	0	0	0	**0**
Illinois	22	16	34	219	**291**	70	0	0	0	**70**
Indiana	3	0	6	6	**15**	3	0	0	0	**3**
Iowa	2	0	0	4	**6**	0	0	0	0	**0**
Kansas	0	2	1	8	**11**	1	0	0	0	**1**
Kentucky	4	1	12	151	**168**	10	0	0	3	**13**
Louisiana	2	7	53	164	**226**	47	0	1	4	**52**
Maine	0	0	0	1	**1**	0	0	0	0	**0**
Maryland	2	0	5	109	**116**	63	6	5	16	**90**
Massachusetts	10	8	23	39	**80**	260	15	40	38	**353**
Michigan	6	10	9	140	**165**	15	0	0	27	**42**
Minnesota	0	0	1	18	**19**	0	1	0	0	**1**
Mississippi	0	0	8	13	**21**	0	0	1	11	**12**
Missouri	0	1	10	14	**25**	8	0	0	0	**8**

TABLE 6.—Cuban and Haitian Entrant Arrivals by State of Initial Resettlement: FYs1992-1995[1] (continued)

State	Cuba					Haiti				
	1992	1993	1994	1995	92-95	1992	1993	1994	1995	92-95
Montana	0	0	0	0	0	0	0	0	0	0
Nebraska	0	0	0	6	6	0	0	0	0	0
Nevada	70	87	298	362	817	18	1	0	0	19
New Hampshire	0	0	0	1	1	0	0	0	0	0
New Jersey	92	62	309	791	1,254	297	8	13	4	322
New Mexico	105	135	378	417	1,035	0	0	0	0	0
New York	38	48	184	718	988	590	70	74	29	763
North Carolina	6	0	4	17	27	13	0	0	0	13
North Dakota	0	0	0	1	1	0	0	0	3	3
Ohio	0	0	8	12	20	38	0	0	0	38
Oklahoma	0	1	2	10	13	0	0	0	0	0
Oregon	0	1	22	219	242	54	3	11	19	87
Pennsylvania	4	5	19	89	117	72	5	2	20	99
Rhode Island	0	0	0	3	3	11	0	0	0	11
South Carolina	2	0	0	2	4	0	0	0	0	0
South Dakota	0	0	0	0	0	0	0	0	0	0
Tennessee	2	7	0	53	62	16	5	0	0	21
Texas	73	62	367	505	1,007	22	4	0	0	26
Utah	0	0	0	0	0	0	0	0	0	0
Vermont	0	0	0	0	0	0	0	0	0	0
Virginia	0	1	8	154	163	19	2	2	9	32
Washington	0	1	0	21	22	0	0	0	0	0
West Virginia	0	0	0	1	1	0	0	0	0	0
Wisconsin	1	0	4	9	14	0	0	0	0	0
Wyoming	0	0	0	0	0	0	0	0	0	0
Unknown[2]	10	21	48	150	229	4	1	1	0	6
Total	**2,811**	**3,772**	**12,781**	**30,920**	**50,284**	**10,383**	**693**	**1,577**	**862**	**13,515**

[1] Does not include Cuban and Haitian arrivals with refugee status
[2] Includes unknown States

Demographic Impact

Although refugees constitute a small portion of total immigration, to the extent that refugees differ from immigrants in their characteristics, their impact can be substantially different. Most refugee groups in recent years have been considerably younger than the resident population of the United States and younger than other immigrants as well. The median age of arriving Southeast Asian refugees has generally been between 16 and 24 years of age. Other recent refugee groups average from early to midtwenties, with the exception of Soviet refugees. The average age of refugees from the former Soviet Union has been in the early thirties.

A young refugee population has a disproportionate impact on certain institutions, such as local school systems. In areas where refugees settle in large numbers, many children from homes where English is not used enter the public school system. This enrollment creates a need for special teaching approaches and, where the numbers are particularly high, for extra classrooms and teachers. Many young refugee adults seek English language training in community colleges or similar programs, and Federal refugee social services grants often fund this type of training.

The youthfulness of the refugee population at time of arrival may actually facilitate their successful labor market incorporation. The contraction of the domestic supply of teenagers and young adults has made it possible for many local labor markets to accommodate growing numbers of young refugee workers. Evidence suggests that adjustment to a host labor market may also be easiest when it occurs early in one's working life.

At the other end of the age spectrum, the small number of elderly refugees means that this population currently makes few demands on major programs for retirees, such as Social Security and Medicare. While about 1 out of 8 Americans is currently aged 65 or older, only about 1 out of 14 arriving refugees is in that age group. By the time most of today's refugees are ready to retire, they will have contributed for years to the nation's Social Security, Medicare, and other pension systems.

Economic Impact

The economic impact of refugee arrivals depends on many factors, such as their work skills and English language ability, the labor markets in the areas in which they are resettled, and the availability of special programs to ease their transition into the U.S. labor force. Refugees settling in regions of low unemployment may find the labor market fairly receptive to their skills. However, some refugees settle in labor-surplus areas, such as California's Central Valley. In this case, their economic impact may not be positive.

In the short term, the primary question is if refugees are obtaining employment that enables them to become self-sufficient. ORR conducts an annual native-language survey of refugees, entrants, and Amerasian immigrants who have come to the United States during the 5 previous years. The most recently published survey, conducted in October 1994 includes interviews with 1,751 refugee households. Survey results reveal the following:

- Employment increases with length of residence in the United States.
- Use of public assistance varies widely among refugee households.

Results from the 1994 survey indicate that the employment-to-population ratio (EPR) of refugees 16 or older who have come to the United States during the 5 previous years was 35.4 percent, compared with an equivalent rate of 63.2 percent for the overall U.S. population. As in previous years, the EPR rose with length of residence in the United States. The survey reported an EPR of 28.3 percent for refugees in the United States equal to or less than 12 months and an EPR of 43.7 percent for refugees in the United States more than 4 years.

The 1994 survey also indicates that 30.5 percent of refugee households were self-supporting, although often at low income levels. About 12.7 percent of households were among the ranks of the working poor, having some earned income, but still qualifying for public assistance. Slightly more than one-third (34.4 percent) of

the refugee households had no earned income and depended entirely on public assistance. The remaining refugee households received neither assistance nor earned income in the month of the survey. Household receipt of public assistance reflects not only problems in finding employment, but also differences in need and ability. Assistance-only households are significantly larger than nonrecipient households (4.3 vs. 3.8 individuals) and also have fewer wage earners and fewer fluent English speakers than such households. Of the sampled households with no earned income, 59.9 percent had at least one child under 16 years of age.

Refugees often are responsible for improving economic conditions in communities where they settle. Miami's economic rebirth is usually credited to the Cuban refugees who arrived beginning in the early 1960's. More recently, the Vietnamese refugees who began arriving in 1975 have revitalized commercial neighborhoods in many cities by establishing restaurants, specialty shops, and other businesses. Precise measures of the economic contributions of refugees are not available.

Geographic Distribution

Just as arriving immigrants in past years tended to concentrate and form ethnic communities in certain areas, so have recent refugees. About three-quarters of all Southeast Asian refugees since 1975 have resettled in just 10 States. Thirty percent reside in California alone. The size of current refugee communities will continue to grow with admission of additional family members because of reunification cases.

The more than 767,000 refugees from areas outside Southeast Asia who have arrived since 1975 have resettlement patterns more spread out than the Indochinese. This trend has tended to diffuse the impact of refugee arrivals upon local communities. Large numbers of the non-Indochinese refugees have resettled in cities in the Northeast and the Midwest. Of the non-Indochinese refugees who arrived from FYs1975-1994, New York received the largest number, about 145,000, with California in second place with around 124,000, and Florida third with about 58,000.

The ethnic composition of States' refugee populations varies widely. Sixty-one percent of the arrivals since 1975 have been Indochinese. Nine States resettled a population of more than 90 percent Indochinese, while only four States resettled a refugee population composed of more than 50 percent non-Indochinese. New York had the highest proportion of non-Indochinese refugee arrivals (77 percent), followed by Florida (69 percent), New Jersey (58 percent), and Maryland (53 percent).

As the ethnic composition of the arriving refugee population shifts in response to new needs, so will the geographic placement patterns of these new arrivals. During FYs1992-1994, 36.5 percent of arrivals were Southeast Asian, compared with 44 percent from FYs1989-1991 and 65 percent during the previous 5 years. The increase in refugees from Cuba, Haiti, Iraq, Somalia, the former Yugoslavia, and the former Soviet Union has been especially strong. If this trend continues, States that already have concentrations of refugees from those areas should expect increases in their share of total arrivals.

The impact of refugees should be placed in the context of total legal immigration. Nationwide in FY1987, there were 10 persons admitted as immigrants for every 1 person newly arriving as a refugee. Since FY1987, refugee admissions have risen sharply, from 58,862 in FY1987 to 126,475 in FY1994. Legal immigration has also risen, so that the proportion of legal immigrants to refugees throughout this period was seven or eight to one, excluding persons legalized under the Immigration Reform and Control Act (IRCA) of 1986. California and New York, the top two refugee resettlement States, are also the top two States of destination for immigrants. Refugees are most likely to have a notable impact when States of small or medium size become a favored resettlement site for a particular refugee group, as in the case of Laotian Hmong refugees in Wisconsin.

Local Impact

The effects that refugees may have on the localities in which they resettle depend not only on numbers, employment, and culture but also on the characteristics of the receiving communities. Likewise the perception as to whether refugees are having positive or negative, limited or major effects on the localities is conditioned by the perspectives of those affected. At the arrival levels that have prevailed in recent years, the growth of most refugee communities is slow compared with the overall size of those communities, and the impact of the new arrivals may not be discernible. ORR sponsored an examination of the issue of refugee impact in the early 1980's (Southeast Asian Refugee Resettlement at the Local Level: The Role of the Ethnic Community and the Nature of Refugee Impact). This study focused on the period around 1980 when the flow of refugees from Southeast Asia was at its peak. However, its insights can be generalized to other refugee situations and, with care, to many other immigrant communities as well.

The analysis suggests a distinction between the actual effects that refugees have on the localities in which they settle and the public perceptions of their perceived impact. The study indicates that refugees do have important effects, some positive and some negative, some short term and some long term. These effects must be analyzed separately in areas such as education, housing, employment, and community services.

However, the public perception that refugees have a negative impact does not necessarily correspond to their actual effects. In analyzing refugee ethnic communities, the study notes both their role in providing very concrete and tangible support to refugees and perhaps their more important role in providing the kinds of intangible social, cultural, emotional, and even political support to their members that is virtually unavailable from other sources. The precise structure of these ethnic communities varies among the different ethnic groups, among the study's sites, and over time. The study concludes that economic development is also a key element in the general strength of the ethnic community.

Office of Community Services

Community Services Block Grant Program

Program Summary

CSBGs are awarded to States which, in turn, provide grants and contracts to a network of public and private community based organizations (including Community Action Agencies and migrant and seasonal farm-worker organizations) to provide services and undertake activities to ameliorate the causes and conditions of poverty in local communities. CSBG funds also are made available to Indian Tribes who apply directly to the Office of Community Services (OCS). In FY1994, $397 million was appropriated to carry out the purposes of the CSBG program.

Recipients of CSBG funds are required to provide a range of services and activities to address the following needs: employment, education, making better use of available income, housing, nutrition, emergency services, and health. States and Indian Tribes have the flexibility to provide, consistent with the statute, such services and activities that they determine best meet the needs of low-income individuals and families.

Impact of Immigration on CSBG Program

Federal data regarding which immigrants can, and do, access CSBG programs are unavailable. There has been no statutory or regulatory requirement to collect such information either on the part of OCS or the States or tribes receiving CSBG funds. Because the CSBG budget is not calculated based on the number of individuals served, there is no impact directly attributable to immigrant or citizen use.

Discretionary Grants Program

Program Summary

In FY1994, the CSBG Discretionary Grants program provided $50.6 million in assistance to programs of national and regional significance. Assistance is available on a competitive basis to the following entities: private, locally initiated community development corporations that sponsor enterprises providing

employment, training, and business development opportunities for low-income residents; public and private nonprofit agencies that provide activities benefiting migrants and seasonal farmworkers; public and private organizations that carry out programs in rural housing and community facilities development; and private, nonprofit organizations that provide recreational activities for low-income youth.

Impact of Immigration on Discretionary Grants Program

Funding is provided for the development of projects to aid low-income individuals in general and does not focus on any particular needy population, such as immigrants or refugees. Eligible organizations representing such groups must compete with all other applicants for funding. Immigrants and refugees probably receive services from projects funded under the Discretionary Grants Program, particularly from projects directed toward serving migrants and seasonal farmworkers, but there are no data available indicating the number and location of such users. There are no restrictions on serving immigrants in projects funded under this program.

Community Food and Nutrition Program

Program Summary

The Community Food and Nutrition Program in FY1994 provided $7.9 million in assistance to public and private agencies at the community-based, State, and national levels for the purposes of coordinating existing food assistance resources; assisting in identifying sponsors of child nutrition programs and initiating new programs in underserved and unserved areas; and developing innovative approaches at the State and local levels to meet the nutritional needs of low-income people. Funding for this program is provided on a competitive basis as well as distributed to States on a formula basis.

Impact of Immigration on Community Food and Nutrition Program

The impact of immigration on this program is similar to that of the Discretionary Grants Program. While there are no data available on the extent to which this program serves immigrants; it is reasonable to assume that immigrants who are served by this program benefit to the same extent as citizens who also are served.

Low Income Home Energy Assistance Program (LIHEAP)

Program Summary

LIHEAP helps low-income people meet the costs of heating and cooling their homes. In FY1994, $1.4 billion was appropriated for the regular program, and an additional $300 million in contingency funds was released to meet energy emergency need. Recipients of funding in FY1994 were the States, the District of Columbia, Indian Tribes and tribal organizations, and U.S. territories.

Impact of Immigration on LIHEAP

There is no Federal information on the extent to which immigrants can, and do, access LIHEAP. The LIHEAP statute does not specify immigrants as a target group for assistance. Also, because the budget for LIHEAP is not determined by the number of persons who access its services, there is no effect on its budgetary total attributable to immigrant access.

Social Services Block Grant

Program Summary

SSBG (Title XX of the Social Security Act) is the major source of Federal funding for social services programs in the States. SSBG provides formula grants directly to the 50 States, the District of Columbia, and eligible territories and commonwealths.

Under SSBG, Federal funds are available without a matching requirement. In FY1994, States received a total allotment of $2.8 billion. Within the specific limitations in the law, each State has the flexibility to determine what services will be provided, who is eligible to receive services, and how funds are distributed among the

various services offered. State and local Title XX agencies (that is, county, city and regional offices) may provide these services directly or purchase them from qualified agencies and individuals.

Also, in the Omnibus Budget Reconciliation Act of 1993, Congress amended Title XX of the Social Security Act to provide a one-time set-aside amount of grant funds totaling $1 billion for localities designated as Empowerment Zones and Enterprise Communities (EZ/EC). EZ/EC SSBG funds are separate and distinct from the regular Title XX Social Services Block Grant in both the flexible program uses for the funds and the decision-making authority for determining those uses.

Specifically, Title XX was amended to permit a greatly expanded range of programmatic activities that can be financed with EZ/EC SSBG monies, as opposed to the more limited options for regular SSBG funds, including economic and community development and infrastructure projects. Furthermore, all decision-making authority for using EZ/EC SSBG funds to finance particular activities is vested in the local EZ/EC lead entity and community-based governance process, as opposed to the State under the regular Title XX Social Services Block Grant; in the EZ/EC program, the State primarily functions as a "pass-through" funding conduit for the EZ/EC SSBG award.

EZ/EC SSBG funds were provided to 6 urban and 3 rural Empowerment Zones and 95 Enterprise Communities to assist those localities in addressing their specific needs. Among the programs that the EZ/ECs identified as relevant to their communities are: programs to train and employ zone residents in the construction and rehabilitation of public infrastructure and affordable housing; after-school programs to keep schools open during the evenings and on weekends; and drug and alcohol prevention and treatment programs that provide comprehensive services for pregnant women, mothers, and their children.

Impact of Immigration on SSBG Programs

Each State must submit a preexpenditure report to the Secretary of HHS on the intended use of SSBG funds. The only requirement in the statute is that the report include information regarding the type of activities to be funded and the characteristics of the individuals to be served. While there is no specific information available in these reports on the social services provided to immigrants and refugees, a State has the flexibility to offer the same services under SSBG to these groups that are available to other residents of the State. With the enactment of PRWORA, States have the option to deny SSBG assistance to legal immigrants beginning January 1, 1997. Because the budgets for SSBG programs are not based on the number of individuals that use their services, immigrant use has no effect on the budget outlays.

Although many of the 104 EZ/EC localities receiving EZ/EC SSBG funds may include immigrant populations, the size and configuration of those designated areas prohibits a valid assessment of that population and the services they currently may be receiving. It is unclear if EZ/EC SSBG funds, with their unique characteristics distinct from regular SSBG monies, will be affected directly by PRWORA.

Head Start

Program Summary

Head Start is a national program that provides comprehensive educational, medical, health, nutritional, social, and other services to primarily low-income preschool children and their families. In FY1994, about 740,000 children received Head Start services. Up to 10 percent of Head Start's enrollment may be reserved for preschool children from families above the Federal poverty level (FPL). Also 10 percent of enrollment must be reserved for preschool children with disabilities (currently, about 13 percent of Head Start's national enrollment are children with disabilities). In addition, Head Start funds programs for Indian and migrant children. While these programs generally serve children from ages 3 or 4 to the age of compulsory school attendance, some are authorized to serve children from birth onward. In FY1994, there were 1,405 Head Start grantees and approximately 600 delegate agencies in the 50 States, the District of Columbia, and eligible territories and commonwealths.

Impact of Immigration on the Head Start Program

There are no data on the number of immigrants being served by the Head Start program. As far as the budget is concerned, because Head Start's budget is not based on the number of children and families served, immigrant access to this program does not affect it.

Office of Family Assistance

Aid to Families With Dependent Children (AFDC)

As indicated before, AFDC is being replaced by TANF with the enactment of PRWORA on August 22, 1996.

Program Summary

The AFDC program (Title IV-A of the Social Security Act) is a federally funded program administered by States and certain territories. In the AFDC program, States make assistance payments to needy families with dependent children deprived of parental support or care because of a parent's absence, death, incapacity, or the unemployment of a parent who is the principal earner.

To become eligible for AFDC payments, the individual must be a citizen or lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. However, provisions included in IRCA disqualified newly legalized immigrants from participation in the AFDC program for a period of 5 years from the date of receipt of their legalized status; the only exceptions to this disqualification are Cuban and Haitian entrants.

A sponsored alien, not otherwise disqualified under IRCA, who applies for AFDC within 3 years of his or her entry into the United States will be evaluated by having the sponsor's income and resources deemed available to the alien according to a prescribed formula for a period not to exceed 3 years from the alien applicant's date of entry.

In FY1994, total State and Federal expenditures for the AFDC program were $26.2 billion.

Impact of Immigration on AFDC

Table 7 shows the AFDC recipiency rates for legal immigrants from 1990-1994, not including recipients of emergency assistance.[2] According to this table, the legal immigrant proportion of all AFDC recipients has remained relatively modest, between 4 and 6 percent of the total AFDC population. There has been an increase from 1990-1994, from 4.2 percent to 5.8 percent, with most of the increase occurring from 1992-1994 and attributable primarily to increased use by refugees and legal immigrants legalized under IRCA who began to be eligible for AFDC around 1992.

TABLE 7.—AFDC Recipiency Rates for Legal Immigrants

	1990	1991	1992	1993	1994
# of Legal Immigrant (L.I.) Recipients	484,917	544,211	634,233	722,814	823,318
# of All AFDC Recipients	11,518,748	12,657,236	13,596,518	14,045,207	14,246,450
% of L.I. AFDC Recipients	4.2	4.3	4.7	5.1	5.8

[1] These figures are based on the AFDC Quality Control File, a sample of State administrative data that was used to study the trends in immigrant usage of AFDC. Quality Control data is drawn from monthly samples provided by each State and is used to determine errors in payments to recipients. Some potential problems with the AFDC Quality Control data include an insufficient number of sample immigrant cases in some States and problems relating to the proper coding of citizenship status in some States.

In addition, according to the aforementioned GAO report, most AFDC households that included legal immigrants also contained citizen recipients. Moreover, the report confirms that nearly one-third of immigrants receiving AFDC are refugees.

Emergency Assistance (EA)

Program Summary

EA is a State-administered optional program that provides temporary financial assistance and services to needy families with children to prevent destitution and provide shelter. The Federal Government shares 50 percent of the costs of these benefits with the States. If a State elects to operate an EA program, it must provide assistance to any family member, otherwise eligible for AFDC, including one who is a citizen or an alien lawfully admitted for permanent residence or otherwise residing in the United States under color of law. States also have the option to provide EA to undocumented immigrants.

States have flexibility in defining what constitutes an emergency and the type and amount of assistance that they will provide. Assistance may be in the form of cash, services, or items a family needs, such as food, clothing, and furniture. Federal matching funds are available only for emergency assistance that the State authorizes during one 30-day period in any 12 consecutive months. Funds may be available to meet needs that arose before the 30-day period or that extend beyond the 30-day period.

In FY1994, total Federal/State expenditures for the EA program were approximately $1.56 billion.

Impact of Immigration on EA Program

There is no Federal information available on the impact of immigration on the EA program.

Office of Child Support Enforcement

Program Summary

Established in 1975, the Child Support Enforcement (CSE) program is a joint Federal and State effort (Title IV-D of the Social Security Act). Its goals are to ensure that children are supported financially by their parents, to foster family responsibility, and to reduce welfare costs.

Impact of Immigration on CSE Program

Data on immigrants' use of CSE services are not available. CSE cases fall into four categories: AFDC, non-AFDC, Medicaid only, and foster care. There are no restrictions or limitations on use of services by immigrants. However, it is known that in FY1994, approximately 5.8 percent of AFDC recipients were non-U.S. citizens. It can be projected that the AFDC portion of the CSE caseload probably has a similar percentage of non-U.S. citizens.

Administration of Developmental Disabilities (ADD)

Program Summary

ADD administers the programs authorized under the Developmental Disabilities Assistance and Bill of Rights Act, as amended. The goal of these programs is to ensure that individuals with developmental disabilities and their families participate in the design of and access to, culturally competent services, supports, and other assistance and opportunities that promote independence, productivity, integration, and inclusion into the community. The ADD programs work in partnership with individuals with developmental disabilities and their families, State governments, local communities, and the private sector to address such issues as prevention, diagnosis, early intervention, therapy, education, training, employment, leisure opportunities, and community and institutional living.

Many services supported by ADD and provided by State and local communities are available to immigrants and refugees with disabilities and their families. The ADD program comprises the following four programs:

- State Developmental Disabilities Councils, which promote capacity building and advocacy, the development of a consumer- and family-centered comprehensive system, and a coordinated array of supports, and other assistance designed to help people with developmental disabilities.
- The Protection and Advocacy (P&A) program, which provides for the protection and advocacy of legal and human rights through formula grants to States.
- University Affiliated Programs (UAP), which provide interdisciplinary training, exemplary service, technical assistance, and information dissemination activities through a grant program.
- Projects of National Significance (PNS) are awards to innovative public or private nonprofit institutions that seek to enhance the independence, productivity, integration, and inclusion into the community of people with developmental disabilities. Monies also support the development of national and State policy.

Impact of Immigration on ADD

The impact of immigration on local ADD-supported programs is unknown and difficult to assess, because eligibility for ADD-related programs is not based on immigration status. However, it is reasonable to assume that some immigrants benefit from ADD programs and services. Because the budgets for ADD's programs are not calculated based on the number of individuals served, immigrant use has no effect on the total budget.

Public Health Service

Substance Abuse and Mental Health Services Administration (SAMHSA)

Agency Summary

SAMHSA (1992-1994) and its predecessor, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) (1988-1991), administers several programs that might be affected by immigration into the United States: the Refugee Mental Health Program; two SAMHSA-administered block grants established in 1992 and their ADAMHA-administered precursor; a program providing assistance to homeless individuals with serious mental illness; a program providing comprehensive community-based services for children with serious emotional disturbance; a program providing protection and advocacy for individuals with serious mental illness; a program that provides assistance to communities in developing resources to prevent substance abuse; and several demonstration programs. Descriptions of these programs are included in Appendix A, Additional Information on SAMHSA Programs.

Refugee Mental Health Program

Program Summary

From 1988-1991, ADAMHA supported between 110 and 150 beds at St. Elizabeth's Hospital in Washington, DC, which were allocated for mental health assessment and treatment of Cuban refugees and other persons from abroad. ADAMHA also had cooperative agreements that provided a range of 132 to 152 beds for community mental health care in halfway house settings. The Department of Justice provided funding ranging between $12 million to $14 million annually for this program. In October 1992, in conjunction with the reorganization of ADAMHA, the activities of the Refugee Mental Health Program were transferred to the Refugee Mental Health Branch, Center for Mental Health Services (CMHS), SAMHSA. In addition to the Cuban/Haitian activities, the Branch develops other consultative activities with Federal agencies, in particular

ORR. These activities are supported by ORR, through an interagency agreement that transferred funds to CMHS for support of these activities. [3]

Impact of Immigration on the Refugee Mental Health Program

Immigration policies that potentially affect mass migrations or repatriations (for example, from Cuba or Haiti) have a significant impact on the Refugee Mental Health Program's service delivery systems.

Block Grants

Program Summaries

The Community Mental Health Services block grant provides funds to the States and territories to enable them to carry out the States' plans for providing comprehensive community mental health services to adults with serious mental illness and to children with a serious emotional disturbance; evaluate programs and services carried out under the plan; and conduct planning, administration, and educational activities related to providing services under the plan.

The Substance Abuse Prevention and Treatment (SAPT) block grant provides funds directly to States to provide substance abuse prevention and treatment services based on State needs assessments and State plans.

Before the establishment of SAMHSA in 1992, ADAMHA administered the Alcohol, Drug Abuse, and Mental Health Services (ADMS) block grant, which provided financial assistance to States and territories to support programs and activities involving the prevention and treatment of alcohol and drug abuse; and to support community mental health centers for the provision of services for individuals with mental illness and children and adolescents with serious emotional disturbance.

Impact of Immigration on Block Grant Programs

Because the funding mechanisms for the SAMHSA and ADAMHA block grants are primarily based on population-driven formulas for determining State allotments, a significant increase in a State's population caused by immigration would require an increase in the State's allotment. Other States' allotments would decrease correspondingly. However, receipt of services from these programs has not been dependent on citizenship or immigrant status, and there is no information available regarding the immigrants' use of these services.

Assistance to Homeless Individuals With Mental Illness

Program Summary

SAMHSA (and from 1988-1991, ADAMHA) supports a program to assist homeless persons with severe mental illness, initially through the Mental Health Services to the Homeless (MHSH) block grant, and then through the Projects for Assistance in Transition from Homelessness (PATH) formula grant program. Both the MHSH block grant and the PATH program have provided outreach and mental health treatment programs to homeless persons with serious mental illness and, under the PATH program, to those individuals at risk of homelessness.

[2] In September 1995, the Cuban/Haitian activities of the Refugee Mental Health Branch were transferred to the Department of Justice. At the same time, the consultative activities, funded by ORR, were transferred to the Special Programs Development Branch, CMHS, and SAMHSA. Since September 1995, Special Programs Development Branch staff, through an interagency agreement with ORR, provide consultation and technical assistance, to Federal, State, and local agencies, and ORR-funded programs, on refugee mental health. These activities include onsite and phone consultation on program development and implementation; development and dissemination of technical assistance documents; and development and provision of workshops and training to resettlement and mental health agency staff.

Impact of Immigration on Assistance to Homeless Individuals with Mental Illness Program

Eligibility for this program has not been dependent on citizenship or immigrant status. Therefore, no information is available regarding the immigrants' use of these services.

Comprehensive Community Mental Health Services for Children and Their Families Program

Program Summary

The Comprehensive Community Mental Health Services for Children and Their Families program was authorized in 1992 in the ADAMHA Reorganization Act to provide grants to States, political subdivisions, Native American reservations, and tribal organizations for provision of an array of community-based services organized into a system of care for children with serious emotional, behavioral, or mental disorders, and their families.

Impact of Immigration on Comprehensive Community Mental Health Services for Children and Their Families Program

Eligibility for this program's services is not conditional based on immigrant status. There is no information available regarding the immigrants' use of these services.

Protection and Advocacy for Individuals With Mental Illness (PAIMI)

Program Summary

The PAIMI Act of 1986 authorizes formula grant allotments to be awarded to P&A systems that have been designated by the Governor in each State to protect the rights of and advocate for individuals with disabilities. The allotments are to be used to pursue administrative, legal, and other appropriate remedies to redress complaints of abuse, neglect, and rights violations and to protect and advocate the rights of individuals with mental illness through activities to ensure the enforcement of the Constitution and Federal and State statutes.

Impact of Immigration on PAIMI

Receipt of services from this program has not been dependent on citizenship or immigrant status, and information is not available regarding the immigrants' use of these services.

Demonstration Grant Programs

Program Summaries

The Community Partnership program, initiated in 1990, heralds a new approach for substance abuse prevention in the Nation. The program is predicated on the concept that empowered communities can martial their resources to solve their own problems, such as substance abuse, violence, the human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), drunk driving, school failure, and delinquency. Community Partnership grants permit representatives from government, business, health, religion, academia, schools, criminal justice, and other individuals to join together to assess, design, and implement communitywide prevention efforts.

SAMHSA, and its predecessor ADAMHA, supports several additional demonstration programs designed to expand services and knowledge concerning effective delivery of substance abuse and mental health services in distinct settings and to distinct groups of individuals with addictive and mental disorders. These programs have included the Capacity Expansion, Target Cities, Critical Populations, Criminal Justice, Treatment Campus, HIV/AIDS Outreach, Women and Children, and National Capital Area Demonstration and the DC Initiatives programs funded by SAMHSA's Center for Substance Abuse Treatment; the High Risk Youth and Pregnant and Postpartum Women and Infants programs funded by SAMHSA's Center for Substance Abuse Prevention; and the Access to Community Care and Effective Services and Support and Community Support; and AIDS demonstration programs funded by SAMHSA's Center for Mental Health Services.

Impact of Immigration on Demonstration Programs

Eligibility for services from SAMHSA's demonstration programs are not conditional based on citizenship or immigrant status. Consequently, there is no information available regarding the immigrants' use of these services. However, because the programs' budgets are not determined by the number of persons accessing their services, immigrant access would not affect the total budget.

Centers for Disease Control and Prevention (CDC)

Agency Summary

The mission of CDC is to prevent unnecessary illness and premature death. CDC strives to achieve national prevention objectives by accomplishing the following:

- Conducting surveillance, epidemiological investigation, and laboratory research.
- Serving as national and international reference laboratories.
- Providing assistance, including grants, to State and local health departments.
- Disseminating findings through partners in academic institutions, medical care settings, and business and labor groups.

Services funded by CDC and provided by State and local health departments are available to immigrants and refugees. For example, CDC's Preventive Health and Health Services block grant is designed to give States flexibility to fund priority prevention programs tailored to specific needs. This block grant funds a wide variety of preventive health services. CDC also funds State-level activities in immunization, tuberculosis control, sexually transmitted disease prevention and control, HIV/AIDS prevention and education, health education, and health promotion. In addition, CDC manages a national program for control of infectious diseases. Through the Refugee Health Assessment Program, CDC grant funds are used to supplement local, State, and other Federal resources for providing initial health screening for infectious disease and referral services to refugees.

Impact of Immigration on CDC Programs

The impact of immigration on local preventive health services supported by CDC grant funds is unknown and difficult to assess. Eligibility for CDC-supported services is not based on immigration status, and national data on the immigration status of recipients is not maintained. However, it is reasonable to assume that immigrants benefit from CDC services. Therefore, changes in immigration and program eligibility could affect the local operation of CDC programs substantially, particularly in communities with high concentrations of immigrants. These programs are not based on the number of individuals served; therefore, immigrant use has no effect on the budget totals.

Health Resources and Services Administration (HRSA)

Agency Summary

The programs administered by HRSA are designed to improve the health of the Nation by accomplishing the following:

- Ensuring that quality health care is available to underserved and vulnerable populations.
- Promoting primary care education and practice.

HRSA, in providing national leadership in health care and public health, works to ensure that health care is available, independent of cultural and linguistic factors or economic circumstances. The diversity of programs supported by HRSA reflects this philosophy and unity of purpose.

HRSA administers preventive and primary health care programs, which address the needs of disadvantaged and underserved populations. These programs include the following:

- Community and Migrant Health Centers.

- Maternal and Child Health Care services, including pediatric emergency medical services.
- Health services for the homeless and residents of public housing.
- Ryan White grants for the provision of HIV/AIDS services.

Program descriptions for these programs are in Appendix B, Additional Information on HRSA Programs.

Impact of Immigration on HRSA Programs

Because HRSA supports programs located in areas most accessible to underserved and disadvantaged populations, it can be assumed that these programs serve immigrants, particularly the Community and Migrant Health Centers. However, data that are collected on recipients do not identify which of the recipients are immigrants.

Approximately 600 Community and Migrant Health Centers across the United States provide primary health care for more than 6 million persons with a culturally sensitive, family-oriented focus. Appropriated funds for the community health centers in FY1994 was $603.7 million; for the migrant health centers the amount was $59.0 million. Among services that may specifically benefit immigrants are the provision of the following:

- Medical documents that may serve as proof of residence in the United States.
- Physician examinations in connection with immigration and refugee processes requiring follow-up care when medical problems have been identified.

Because the budgets for HRSA programs are not based on the number of persons served, immigrant access to these programs has no effect on the total budget.

Administration On Aging (AoA)

Agency Summary

There are 44 million people in America age 60 or older. Some of these older individuals are at risk of losing their independence, including 4 million people over age 85, those living alone without a caregiver, members of minority groups, older persons with physical or mental impairments, low-income older persons, and those who are abused, neglected, or exploited.

AoA was established by the Older Americans Act of 1965 to meet the diverse needs of the growing number of older people. AoA is the Federal focal point and advocacy agency for older persons. It works closely with its nationwide network of regional offices, State units on aging, area agencies on aging, and tribal organizations to plan, coordinate, and develop community-level systems of services designed to meet the unique needs of older persons and their caregivers. It funds supportive in-home and community services, including access services (for example, information and referral, transportation, and case management), in-home services (for example, home repair, home-delivered meals, personal care, homemaker-home health aide), community services (for example, senior centers, congregate meals, day care, nursing home ombudsmen, health promotion, etc.), and care-giver services (for example, respite, counseling, and education).

Impact of Immigration on the AoA

The effect of immigration on local AoA supported services is unknown and difficult to assess because AoA programs do not collect information on immigration status. However, it is reasonable to assume that immigrants benefit from AoA programs and services, particularly in communities with high concentrations of older immigrants. As for the budget, immigrant use of AoA programs would not affect the total budget because it is not calculated based on the number of persons accessing those programs.

Health Care Financing Administration (HCFA)

Medicaid

Program Summary

The Medicaid program is a Federal- and State-financed entitlement program that purchases medical assistance for certain low-income families and persons who are aged, blind, or have disability. In FY1994, 35.1 million individuals were enrolled in the program, and Medicaid benefits (Federal portion) totaled $78.8 billion.

Table 8 shows the following categories of recipients that make up the 35.1 million Medicaid enrollees in FY1994.

TABLE 8.—Medicaid Enrollees, FY1994

	# (millions)	%
Total	**35.1**	**100.0**
Aged	4.0	11.4
Blind/Disabled	5.6	16.0
AFDC-Children	16.9	48.1
AFDC-Adults	7.7	21.9
Other	0.8	2.3

Impact of Immigration on the Medicaid Program

Generally, Title XIX of the Social Security Act permits full Medicaid eligibility to the following groups of immigrants: lawful permanent residents and persons permanently residing in the United States under color of law. Immigrants not listed above include: immigrants lawfully admitted for a temporary period, such as students and visitors; persons who entered the country legally whose visas have expired; and persons who have entered the country illegally, who have not been apprehended by the INS and have no immigration status of any kind. These undocumented immigrants are eligible for emergency services only under Medicaid, if all other requirements for Medicaid eligibility are met. Emergency services include any emergency medical condition that puts the immigrants' health in serious jeopardy (including labor and delivery).

Because HCFA does not require States to submit data on the percentage of alien Medicaid recipients and States have not voluntarily reported such information, it is difficult to determine how many of these are legal or illegal immigrants. However, it is assumed that under the AFDC-based eligibility categories, participation by immigrants may have been similar to the 5.8 percent welfare recipiency rate in 1994 (disclosed earlier in this report).

Medicare

Program Summary

The Medicare program is a Federal health insurance program for most people age 65 or older and certain people with disabilities. The Medicare program has two parts; Hospital Insurance (Part A) and Supplemental Medical Insurance (Part B). Generally, most people age 65 and older have access to Medicare Part A benefits, based on their own or their spouse's employment, without having to pay a premium. Medicare Part A is "premium-free" for individuals who meet the age requirement and for whom any of the following three statements is true:

- They receive benefits under the Social Security or Railroad Retirement system.
- They could receive benefits under the Social Security or Railroad Retirement system but have not filed for them.

- The individual or their spouse had Medicare-covered government employment.

Individuals under 65 years of age also can get premium-free Medicare Part A benefits if they have been a disabled beneficiary under Social Security or the Railroad Retirement Board for more than 24 months. For example, an individual who receives Social Security disability insurance (SSDI) benefits for more than 24 months automatically becomes eligible for Medicare. To the extent that welfare reform changes the SSI eligibility criteria for immigrants, such changes consequently will affect disabled immigrant access to Medicare.

Part B benefits are available to almost all resident citizens 65 years of age or over; to certain aliens 65 years of age or over (even those who are not entitled to Part A); and to disabled beneficiaries entitled to Medicare Part A. Most Medicare Part B enrollees are eligible for Part B because they are eligible for premium-free Medicare Part A benefits based on the work described previously. All Medicare Part B enrollees pay premiums; presently this amount is 25 percent of the cost of the Medicare benefit.

Table 9 shows the number of individuals enrolled in Medicare on July 1, 1994, and Benefit Payments made during FY1994.

TABLE 9.—Medicare Enrollees (Millions) and Benefit Payments ($ in Billions)

	Medicare Enrollees, July 1, 1994	**Benefit Payments, FY1994**
Hospital Insurance (Part A)	36.5	$101.3
Aged	32.4	89.6
Disabled	4.1	11.7
Supplemental Medical Insurance (Part B)	35.2[1]	58.0
Aged	31.4	50.2
Disabled	3.7	7.8

[1]Numbers do not sum to total because of rounding.

Impact of Immigration on the Medicare Program

Legal immigrants and citizens who are not otherwise eligible may opt to buy in to the Medicare program if they meet certain eligibility criteria. They must be over age 65 and must meet a 5-year U.S. residency requirement before becoming eligible to purchase Medicare Part B. While eligibility for Part A benefits is not explicitly conditioned on such a requirement, purchasers of Part A must be eligible for Part B, effectively requiring all individuals who exercise this option to meet the 5-year residency requirement for both Parts A and B.

The Medicare buy-in option is one way immigrants may enroll in Medicare. While data on the number of immigrants who have used this option are not available, there is general information on the number of individuals who have bought into Medicare and the proportion of that group to the total Medicare population. In 1994, less than 1 percent of all Medicare Part A enrollees (approximately 334,000 persons) paid a premium for this coverage. While this percentage is small, it still represents twice as many people who paid premiums in 1990 (approximately 166,000 individuals).

Other than this residency requirement, Medicare does not have any special eligibility requirements for noncitizens or nonresidents. Any individual, meeting the residency requirement, may enroll in Medicare if he or she meets the enrollment requirements related primarily to age and contributions or may purchase it if contributions are not sufficient. In addition, because immigrants are younger than the general population and generally attached to the workforce, new immigrants represent a positive contribution to the Medicare Trust Funds and help support the system.

Social Security Administration

Social Security Retirement, Survivors, and Disability Insurance (RSDI)

Program Summary

The RSDI program is designed to partially replace the income that is lost by a worker and/or his or her family when the worker retires in old age, becomes severely disabled before retirement age, or dies. About 97 percent of the jobs in paid employment and all self-employment are covered under Social Security.

The RSDI program generally treats aliens the same as U.S. citizens. There are two exceptions, as follows:

- Under the alien nonpayment provision, a beneficiary who is not a citizen or national of the United States and has been outside the United States for 6 consecutive calendar months may not be paid benefits beginning with the seventh month of absence. Benefits resume when the beneficiary returns to the United States and remains for 1 full calendar month. Certain exceptions in the law to this general rule allow many aliens to receive their benefits outside the United States without interruption. These exceptions are based, for the most part, on the citizenship of the individual.

- Entitled aliens who are deported for certain reasons under INA may not be paid benefits. Benefits may again be payable if the deported alien is subsequently admitted for permanent residence by the INS.

TABLE 10.—Aliens not Paid RSDI Benefits Under Nonpayment Provisions, By Selected Month

Month	Nonpayment After 6-Month Absence	Nonpayment Due to Disportation
December 1989	10,157	635
December 1990	11,006	778
March 1991	11,570	776
March 1992	13,103	762
March 1995	16,689	951

Note: Figures are not available for 1993 or 1994.

Some aliens enter the United States illegally. Others enter legally but lose their status because they remain in the United States beyond the period of their authorized stay. Many of these aliens work in the United States long enough to become insured for RSDI benefits.

For claims filed before December 1, 1996, individuals in the United States meeting RSDI eligibility requirements are paid benefits without regard to citizenship or alien status. However, effective with applications filed December 1, 1996, or later, an alien must be lawfully present in the United States, as defined by the Attorney General, to receive RSDI benefits in the United States.

Impact of Immigration on RSDI Program

No Federal information on the impact of immigration is available.

Enumeration Process (Issuing Social Security Numbers)

The nine-digit Social Security number (SSN) was originally intended only to keep track of the earnings of people who worked in jobs covered under the Social Security program. By the early 1970's the use of the number expanded as the government and private sector increasingly used it as a multipurpose identifier. Because of the fraud and widespread use of the SSN and the SSN card, Congress enacted legislation requiring all applicants for SSNs to provide evidence to establish age, identity, and citizenship or alien status.

An individual, whether citizen or alien, needs an SSN to obtain a job, pay taxes, or receive benefits under many government benefit programs. SSA issues SSN cards to those aliens admitted for permanent residence and those admitted on a temporary basis, with or without work authority.

Aliens, like all applicants, must meet certain requirements to obtain SSNs. In addition to providing evidence of age, identity, and alien status, applicants age 18 and older applying for original SSN cards must appear for a personal interview. Lawful aliens who want SSN cards for work purposes must prove they are authorized to work, usually by showing their INS documents. SSA issues unrestricted SSN cards to permanent resident aliens and refugees. In September 1992, SSA began issuing SSN cards with the legend "VALID FOR WORK ONLY WITH INS AUTHORIZATION" to aliens lawfully admitted to the United States with temporary work authorization. SSA issues SSN cards with the legend "NOT VALID FOR EMPLOYMENT" to lawful aliens not authorized to work who need an SSN for nonwork purposes (for example, to obtain a driver's license in a State that requires an SSN for that purpose). In February 1996, SSA began defining a valid nonwork reason as a Federal, State, or local statute or regulation that requires the individual to provide an SSN to obtain the benefit or service. SSA issues SSN cards to illegal aliens only when they will be paid benefits under a program financed in whole or in part from Federal funds. They receive cards annotated "NOT VALID FOR EMPLOYMENT."

Impact of Immigration on SSN Issuance

In FY1995, SSA issued about 6 million original SSN cards and about 11.2 million replacement SSN cards. Of the original cards issued, about 1.5 million (about 25 percent) were to aliens (about 63 percent of whom were allowed to work). Of the replacement cards, about 795,000 (about 7 percent) were issued to aliens (about 93 percent of whom were allowed to work).

In FY1994, SSA issued about 6 million original SSN cards and about 10.4 million replacement SSN cards. Of the original cards issued, about 1.4 million (23 percent) were to aliens (about 62 percent of whom were allowed to work). Of the replacement cards, about 790,000 (8 percent) were to aliens (about 93 percent of whom were allowed to work).

In FY1993, SSA issued about 6.2 million original SSN cards and about 10.7 million replacement SSN cards. Of the original cards issued, about 1.5 million (24 percent) were to aliens (about 73 percent of whom were allowed to work). Of the replacement cards, about 800,000 (7 percent) were to aliens (about 92 percent of whom were allowed to work).

In FY1992, SSA issued about 7 million original SSN cards and about 10.7 million replacement SSN cards. Of the original cards issued, about 1.6 million (23 percent) were to aliens (about 74 percent of whom were allowed to work). Of the replacement cards, about 765,000 (7 percent) were issued to aliens (about 91 percent of whom were allowed to work).

In FY1991, SSA issued about 7.5 million original SSN cards and about 10.5 million replacement cards. Of the original SSN cards issued, about 1.7 million cards (23 percent) were issued to aliens (about 75 percent of whom were allowed to work). Of the replacement cards, about 730,000 (7 percent) were issued to aliens (about 88 percent of whom were allowed to work).

The totals for FY1992 through 1995 are shown in Table 11.

TABLE 11.—Original and Replacement SSN Cards Issued: FYs1992-1995

Year	Total Issued	Total Issued to Aliens	% of Total Cards Issued Which Were Issued to Aliens	% of Cards Issued to Aliens Who Were Work Authorized
Original SSN Cards				
1992	7 million	1.6 million	23	74
1993	6.2 million	1.5 million	24	73
1994	6 million	1.4 million	23	62
1995	6 million	1.5 million	25	63
Replacement SSN Cards				
1992	10.7 million	.765 million	7	91
1993	10.7 million	.800 million	7	92
1994	10.4 million	.790 million	8	93
1995	11.2 million	.795 million	7	91

Supplemental Security Income

Program Summary

The SSI program provides cash assistance directly to aged, blind, and disabled persons to help bring their incomes up to a federally established minimum level. SSA administers SSI payments nationwide. Eligibility has been limited to individuals (and their eligible spouses) who are age 65 and over, blind, or disabled; are U.S. citizens or certain aliens; and whose countable income and resources fall below federally established levels.

SSI operates as a program of last resort. Applicants are required to apply for all other benefits for which they may be eligible before evaluation for SSI eligibility. The SSI program then provides monthly payments to make up any difference between countable income and the minimum income floor established by statute. The minimum income in calendar year 1994 was $446 a month for individuals and $669 a month for individuals with an eligible spouse. In all but 12 States, SSI recipients are automatically eligible for Medicaid. In 12 States with more restrictive rules, Medicaid eligibility is determined by the State.

Eligibility of Various Categories of Aliens in the SSI Program

Prior to August 22, 1996, to be eligible for SSI benefits, an individual had to be a U.S. citizen or national, an alien lawfully admitted for permanent residence, or an alien who was a permanent resident under color of law (PRUCOL).

Legislation enacted on August 22, 1996 (and subsequently amended), eliminated the PRUCOL category. Under current law, to be SSI-eligible an alien must be in a "qualified" status and meet one of the exceptions to the general bar on eligibility that applies to qualified aliens.

Qualified aliens include: Lawfully admitted permanent residents (LAPRs); refugees admitted to the United States pursuant to Section 207 of the INA; asylees pursuant to Section 208; parolees under Section 212(d)(5) for a period of at least 1 year; an alien whose deportation has been withheld under Section 243(h) as in effect prior to April 1, 1997, or whose removal has been withheld under Section 241(b)(3); an alien granted conditional entry pursuant to Section 203(a)(7) as in effect prior to April 1, 1980; certain Cuban and Haitian entrants; and certain aliens who have been battered or subjected to extreme cruelty or whose children or parents have been so treated.

Exceptions that permit qualified aliens to receive SSI include (but are not limited to): LAPRs who can be credited with 40 qualifying quarters of work, qualified aliens with U.S. military active duty or veteran status, and qualified aliens who were lawfully residing in the United States on August 22, 1996, and are blind or disabled.

Program Size

Table 12 shows the appropriated Federal funds for FYs1988-1994; the total number of recipients (citizens and aliens) of SSI program benefits in December of each year; and, in addition to Federal funds, State supplementation paid to SSI recipients.

TABLE 12.—Size of Total SSI Program, 1988-1994

Month	Persons Served (millions)		
December 1988	4.5		
December 1989	4.7		
December 1990	4.9		
December 1991	5.2		
December 1992	5.6		
December 1993	6.1		
December 1994	6.4		
Fiscal Year	**Appropriated Funds (billions)**	**Other Resources Available to Program (billions)**	
		Federally Administered	**State Administered**
1988	$12,300,384	$2.7	$0.4
1989	$12,473,953	$3.0	$0.4
1990	$12,034,758	$3.2	$0.5
1991	$17,391,170	$3.2	$0.5
1992	$17,479,491	$3.4	$0.6
1993	$21,237,675	$3.3	$0.6
1994	$27,322,866	$3.1	$0.6

Note: Program data cover all U.S. citizens and aliens.

Number of Aliens in SSI Population

The number of aliens in the SSI population in December of each year from FYs1988-1994 is shown in Table 13.

TABLE 13.—Aliens in the SSI Population, 1988-1994

Month	Aliens Receiving SSI Benefits
December 1988	320,300
December 1989	370,300
December 1990	435,600
December 1991	519,660
December 1992	601,455
December 1993	683,178
December 1994	738,140

Impact of Immigration on SSI Program

Aliens made up 12 percent of the SSI recipients in December 1994.

Alien Participation in the Food Stamp Program

Introduction

The USDA, through FCS, administers the following 13 domestic food assistance programs:

- FSP
- Special Milk Program
- Summer Food Service Program (SFSP)
- National School Lunch Program (NSLP)
- Nutrition Assistance Program in Puerto Rico
- Food Distribution Program on Indian Reservations
- Nutrition Assistance Program in the Commonwealth of the Northern Marianas Islands
- School Breakfast Program (SBP)
- Commodity Supplemental Food Program
- The Emergency Food Assistance Program
- Farmers Market Nutrition Program
- Child and Adult Care Food Program (CACFP)
- Special Supplemental Food Program for Women, Infants, and Children (WIC)

Four programs (FSP, the Nutrition Assistance Program in Puerto Rico, the Nutrition Assistance Program in the Commonwealth of the Northern Marianas, and the Food Distribution on Indian Reservations) help meet the basic needs of low-income families and individuals. The remaining programs provide supplemental benefits to groups with special needs, especially those at different developmental stages: infants, children, child-bearing women, and the elderly.

FSP is the cornerstone of domestic food assistance, accounting for more than 2 out of every $3 spent in FY1995, which is the most recent year of complete data. It provides a monthly benefit to anyone with low income and few assets in the 50 States, the District of Columbia, Guam, and the Virgin Islands. The Nutrition Assistance Program in Puerto Rico, the Nutrition Assistance Program in the Commonwealth of the Northern Marianas Islands, and the Food Distribution Program on Indian Reservations serve a similar function in Puerto Rico and on Indian reservations and the trust territories, respectively. In FY1995, food stamp recipients received $22.8 billion in benefits. In an average month, 26.6 million people received food stamps.

NSLP serves children in schools and residential institutions. It is available to 98 percent of public school children and more than 90 percent of all school children. SBP serves the same group but is not as widely available. It is most frequently found in schools serving high proportions of lower-income students. The Special Milk Program primarily serves children in schools not participating in other child-nutrition programs. CACFP serves children and functionally impaired or elderly adults cared for in daycare centers, family daycare homes, and adult daycare programs. SFSP provides meals to school children in needy areas throughout summer vacation.

WIC serves low-income infants, children and child-bearing women who are found to be at nutritional risk. WIC provides nutritious supplementary food, nutrition education, and referrals to health care services. The Commodity Supplemental Food Program serves essentially the same group and, in addition, provides benefits to the elderly in certain areas.

The Emergency Food Assistance Program provides commodities for home consumption through food banks and other charitable institutions. Commodities for Charitable Institutions provides commodities to soup kitchens and similar organizations to support meal service to needy recipients. The Nutrition Program for the Elderly supplements other programs for the elderly with cash and commodities for meals in senior citizen centers and similar settings.

Four programs (FSP, WIC, NSLP, and the Nutrition Assistance Program in Puerto Rico) paid out more than $34 billion in benefits to program participants in FY1995, 91 percent of all food assistance benefits. FSP alone provided $22.8 billion in benefits to participants, nearly 68 percent of all food assistance benefits in FY1995.

Among the domestic food assistance programs administered by the USDA, FSP is by far the largest and is the only program with explicit Federal statutory restrictions on the eligibility and participation of aliens. Consequently, this discussion focuses exclusively on the extent of participation by aliens in FSP.

What follows is a brief description of FSP, eligible alien categories, a system for verifying eligible alien status, the most recent data available on alien participation in FSP, and current studies on the effect of IRCA on FSP.

The Food Stamp Program

Program Description

FSP is a nationwide program that helps low-income families and individuals buy the food they need to maintain a nutritious diet. In an average month in FY1995, about 26.6 million people received food stamp benefits at an annual cost of $22.8 billion.

The Food Stamp Act of 1977, as amended, defines the group of people who constitute a household for food stamp purposes and sets uniform criteria for their eligibility. These include a gross and net income limit, a resource limit, and a variety of nonfinancial criteria.

To be eligible for food stamps, the gross monthly income of most households must be at or below 130 percent of the Federal poverty guidelines ($20,280 annually for a family of four effective October 1, 1996) and net income—after allowable deductions—must be at or below 100 percent of the guidelines. Households with an elderly or disabled member are subject only to the net income restriction. Gross income includes all cash payments to the household with a few exceptions, including nonrecurring lump sum payments and reimbursement of certain expenses. Deductions subtracted from the household's gross monthly income to determine its net income include: a standard deduction, an earned income deduction, a dependent care deduction, an excess shelter expense deduction, a special medical deduction (for elderly or disabled persons), and a child support deduction for court-ordered payments to another household.

The value of a household's assets is also accounted for in determining program eligibility. Most households are permitted up to $2,000 in countable resources. Households with at least one person age 60 years or older are allowed up to $3,000.

People can qualify for benefits only as part of a "food stamp household." In general, a food stamp household consists of an individual who lives alone or who lives with others but usually purchases and prepares food separately; and groups of individuals who live, purchase food, and prepare meals together.

FSP includes several provisions to encourage able-bodied participants to seek and hold jobs. With certain exceptions, physically and mentally fit food stamp participants must apply for and accept suitable employment.

The maximum amount of food stamps a household can receive is set according to 100 percent of the June cost of the Thrifty Food Plan (TFP) for a reference family of four, adjusted for household size. (TFP is the least-costly food plan developed by the Center for Nutrition Policy and Promotion at USDA, which suggests the amounts of food that could be consumed by males and females of different ages to meet dietary standards). The maximum allotments are revised periodically to reflect changes in the cost of foods included in the TFP. The food stamp benefit issued to each household is based on the number of people in the household and the amount of net income available after subtracting the allowable deductions. Monthly benefits are equal to the maximum allotment for that household less 30 percent of its net income.

Eligibility of Aliens in the Food Stamp Program

Under current regulations, an individual applying for food stamps who is not a citizen of the United States must provide acceptable documentation that verifies that he or she is an eligible alien (the exception is for those applying for disaster assistance benefits).

Before the enactment of PRWORA, the following groups of aliens were considered "eligible aliens":

- Those admitted for permanent residence as an immigrant as defined by INA.
- Those who qualify for conditional entry or are granted asylum under INA.
- Those who are lawfully present in the United States as a result of a grant of parole or an exercise of discretion by the Attorney General for emergency reasons.
- Those for whom the Attorney General has withheld deportation.
- Those who resided continuously in the United States since before January 1, 1972, and are otherwise eligible for lawful permanent resident status (Section 249 of INA) (effective November 6, 1986).
- Those granted lawful permanent residence as a result of the legalization program and are aged, blind, or disabled (Section 245A(b)(1) of INA and 1614 (a) (I) of the Social Security Act) (effective November 7, 1988).
- Those granted lawful residence (temporary or permanent) as a special agricultural worker (Section 210(a) of INA) (effective June 1, 1987).
- Those who will be granted lawful residence (temporary or permanent) as an additional special agricultural worker in FYs1990-1993 (Section 210A(d)) (effective October 1, 1989).
- Those granted temporary resident status who subsequently gained permanent resident status but were prohibited from participating in FSP for 5 years from the date they originally gained temporary status (Sections 245A(a), 245A(b) (I) and 245A(h) (iii)) (applicants could apply for temporary status beginning May 5, 1987, and become eligible to participate in FSP beginning May 6, 1992).

PRWORA dramatically altered the eligibility of aliens for Federal means-tested programs, including FSP. Aliens legally in the United States became ineligible for food stamps unless they belonged to one of the following groups:

- Refugees, asylees, or have had their deportation withheld and were admitted within the last 5 years.
- Active-duty military personnel, honorably discharged veterans, and their spouses and dependent children.
- Those with 40 or more quarters of earnings and no public assistance receipt.

PRWORA provided that those aliens receiving benefits as of August 22, 1996, were allowed to continue receiving benefits until the first of either their recertification date or August 22, 1997. For new applicants, the alien restrictions generally became effective upon enactment of PRWORA. Section 510 of P.L. 104-208, the Department of Defense Appropriations Act of 1997, allowed aliens currently receiving benefits to continue on the caseload until the first recertification after April 1, 1997, or until August 22, 1997.

Alien Verification in the Food Stamp Program

IRCA established the Systematic Alien Verification for Entitlements (SAVE) program, a two-level verification system developed and maintained by the INS. Between October 1, 1988, and August 22, 1996, agencies administering FSP were required to validate the documentation of an alien applicant's status by accessing the INS database or by submitting manual verification requests to the INS. However, PRWORA made the use of SAVE optional.

Alien Participation in the Food Stamp Program

The most recent data available on the extent of participation by lawful aliens in FSP are based on data from the food stamp quality control system. The quality control system is an ongoing review of a sample of food stamp households to determine if they are eligible to participate and receive the correct benefit. FCS uses this sample—consisting of approximately 51,000 participating households during the year—to provide detailed information on the characteristics of participants, including alien status. Aliens are defined as all recipients who are not U.S. citizens; however, because undocumented aliens are not permitted to receive food stamps, almost all aliens are legal permanent residents, refugees, those granted asylum, or individuals who have been granted a stay of deportation.

As shown in Table 14, aliens make up a relatively small proportion of the total food stamp caseload and receive a small fraction of the total benefits. In FY1994, the most recent year for which information on the citizenship status of participants is available, 1.9 million aliens living in 1.1 million households received food stamps. Noncitizens represented 6.7 percent of all food stamp recipients. They received 6.5 percent of all food stamp benefits in that year. The overwhelming majority of alien recipients were legalized permanent residents; other aliens represented less than 25 percent of the alien caseload and only 1.5 percent of all food stamp recipients.

In the general population, resident aliens predominately live in a small number of States (California, Texas, New York, and Florida). Consistent with this pattern, the quality control sample data suggest that alien participation in FSP is highly localized. In 1994, 611,000 alien recipients lived California, 307,000 lived in Texas, 302,000 lived in New York, and 157,000 lived in Florida. These four States accounted for nearly 75 percent of all aliens receiving food stamps. However, because the sample size used to estimate alien participation is relatively small, these estimates should be interpreted with care.

TABLE 14.—Citizenship Status of Food Stamp Recipients: FYs1991-1994

Citizenship Type	1991	1992	1993	1994
Native-born citizen	21,654,000	24,296,000	23,512,000	25,882,000
Naturalized citizen	170,000	187,000	193,000	248,000
Permanent resident	824,000	972,000	1,184,000	1.453,000
Refugee	285,000	288,000	343,000	385,000
Other alien	56,000	31,000	41,000	52,000
Alien subtotal	1,164,000	1,292,000	1,567,000	1,880,000
Foreign-born subtotal	1,334,000	1,479,000	1,760,000	2,127,000
All participants	**22,988,000**	**25,775,000**	**25,752,000**	**28,009,000**

Note: The following notes apply to the above table:
Figures are based on the Integrated Quality Control System (IQCS) full-year data for FYs1991-1994. Because the IQCS data are based on a sample and are weighted by household size, the total number of participants is slightly higher than the actual number of participants.
Because of rounding, numbers may not sum exactly to their totals.
Permanent residents include those coded as having obtained legal status through the IRCA's amnesty provisions.
Refugees include those granted asylum.
Other aliens include aliens granted a stay of deportation, nonimmigrants admitted for a specified period, Mexican citizens with "border" cards, undocumented aliens, and noncitizens whose exact status is unknown.

FCS Studies on the Effect of Immigration Reform on the Food Stamp Program

FCS estimates that IRCA's impact on food stamp participation is modest. More than 1.5 million persons received legal permanent residence under IRCA. The majority of these aliens were barred from receiving many public assistance benefits, including food stamps, for 5 years after applying for legalization. The vast majority of this group applied for legalization between May 5, 1987, and May 4, 1988; thus, the 5-year waiting period ended between May 1992 and May 1993. FCS undertook two studies on this population to examine the economic circumstances of this population and to assess how quickly they applied for food stamps after the 5-year waiting period expanded.

FCS partially funded the *Second Legalized Persons Survey (LPS2)*, which was a follow-up survey of persons granted permanent residency under IRCA who had participated in a 1989 survey. Between April and August 1992, more than 4,000 legalized aliens were interviewed for the follow-up survey, which included questions on family composition, income sources, and asset holdings. The survey data were used to describe the income and financial situations of this immigration group and to estimate the proportion of persons legalized under IRCA who meet the income and asset eligibility guidelines for food stamps. The data became available to the public in February 1996.

A second study funded by FCS, *The Effects of the Immigration Reform and Control Act on the Food Stamp Program*, examined data from LPS2 to estimate the proportion of newly legalized immigrants who qualified for food stamps and also examined State caseload data to estimate the number who receiving food stamps in 1994 and the value of those benefits received. The study results were released in September 1995.

The study found that in 1994 more than a quarter of newly legalized aliens (about 396,000) were eligible for food stamps based on their income and assets, and of these, 190,000 received food stamps. They represented less than 1 percent of the food stamp caseload. They received an estimated $135 million in benefits in FY1994, representing 0.6 percent of all benefits.

Those eligible for food stamps participated at the same rate as the overall Hispanic population. They were twice as likely to live in households with earnings as other food stamp recipients and about as likely to receive AFDC benefits. They tended to live in large households, often containing U.S.-born children.

Appendix A:

Additional Information on SAMHSA[4] Programs

Refugee Mental Health Program

In addition to SAMHSA's authorization, refugee-related activities are authorized under Section 501(c) of the Refugee Educational Assistance Act of 1980 (Public Law No. 96-422). The program mandate is (1) to serve as a focal point for Cuban/Haitian entrant and refugee mental health issues, including liaison with other federal agencies, and (2) to develop, implement, and oversee mental health inpatient and outpatient programs to provide mental health treatment and to enable independent living in the United States.

This program was established in response to the arrival of nearly 125,000 Cubans on the South Florida shores from the Cuban Port of Mariel in 1980. Many of the Cubans had preexisting psychiatric problems. An inpatient mental health treatment facility was established at St. Elizabeth's Hospital in Washington, DC, in October 1980 by the INS and PHS. It has been continuously operated since that time. Once stabilized, patients are generally discharged to community-based halfway house programs. The community-based halfway house program was developed to facilitate the community adjustment of Mariel Cuban entrants who were mentally and/or developmentally disabled and who also often had criminal and/or antisocial histories and substance abuse problems. In addition, the program has been involved in interagency consultation and technical assistance with the Department of Justice's Community Relations Service and Bureau of Prisons.

Substance Abuse Prevention and Treatment (SAPT) Block Grant

The SAPT block grant provides financial assistance to States and territories to support projects for the development and implementation of prevention, treatment, and rehabilitation activities directed to the diseases of alcohol and drug abuse. Funds may be used at the discretion of the States to achieve the statutory objectives, including the fulfillment of certain requirements. Not less than 20 percent of the funds shall be spent for programs for individuals who do not require treatment for substance abuse but to educate and counsel such individuals and to provide for activities to reduce the risk of abuse by developing community-based strategies for prevention of such abuse, including the use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such beverages or products. In FY1993, States were required to expend not less than 5 percent of the grant to increase (relative to FY1992) the availability of treatment services designed for pregnant women and women with dependent children (either by establishing new programs or expanding the capacity of existing programs). A similar requirement existed for FY1994 relative to FY1993 levels. States must require programs of treatment for intravenous drug abuse to admit individuals into treatment within 14 days after they make such a request, or 120 days of a request, if interim services are made available within 48 hours. States provide, directly or through arrangements with other public or nonprofit entities, tuberculosis services such as counseling, testing, treatment, and early intervention services for substance abusers at risk for the HIV disease. Other statutory requirements also apply.

Community Mental Health Services Block Grant

The Community Mental Health Services block grant provides financial assistance to States and territories to enable them to carry out the State's plan for providing comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance; to evaluate programs

[3] The ADAMHA Reorganization Act of 1992, Public Law 102-321 (July 10, 1992), created SAMHSA. The research components of ADAMHA were transferred to the National Institutes of Health, and its services components (the Centers for Substance Abuse Prevention and Substance Abuse Treatment and the new Center for Mental Health Services), with the Office of the Administrator, became the new SAMHSA.

and services carried out under the plan; and to conduct planning, administrative, and educational activities related to providing services under the plan.

Funds may be used at the discretion of the State to achieve the described objectives except for certain requirements and prescribed criteria. Services under the plan can be provided only through appropriate, qualified community programs (which may include community mental health centers, child mental health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental health primary consumer-directed programs). Services under the plan will be provided through community mental health centers only if the centers meet prescribed criteria. For FY1994, the State must expend not less than 10 percent of the grant to increase (relative to FY1993) funding for such centers and for any subsequent fiscal year, the State must expend for such centers not less than an amount equal to the amount expended by the State for FY1994. Up to 5 percent of grant funds may be used for administering the funds. In general, any amount paid to a State under the program shall be available for obligation until the end of the fiscal year for which the amounts were paid and if obligated by the end of such year, shall remain available for expenditure until the end of the succeeding fiscal year. Funds may not be used to provide inpatient services; to make cash payments to intended recipients of health services; to purchase or improve land; to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment; to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or to provide financial assistance to any entity other than a public or nonprofit private entity.

Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grants

The objectives of the ADMS block grant, which was replaced by the SAPT block grant and Community Mental Health Services block grant with the creation of SAMHSA in 1992, is to provide financial assistance to States and territories to support projects for the development of more effective prevention, treatment, and rehabilitation programs and activities to deal with alcohol and drug abuse; and to support community mental health centers for the provision of services for chronically mentally ill individuals, severely mentally disturbed children and adolescents, mentally ill elderly individuals, and for coordination of mental health and health care services provided within health care centers. Each State allotment under the ADMS block grant is available for obligation during the fiscal year it is allotted, and all such obligations must be expended by the end of the subsequent fiscal year. Funds are used at the discretion of each State to achieve the described objectives except for certain requirements. Ninety percent of the total State allotment must be used for mental health and substance abuse services in accordance with an intra-State distribution formula. Not less than 10 percent of the total allotment must be used for alcohol and drug abuse programs and services for women (especially pregnant women and women with dependent children) and demonstration projects for the provision of residential treatment services to pregnant women. Not less than 10 percent of the amount allotted for mental health services must used to provide services and programs for seriously emotionally disturbed children and adolescents.

Projects for Assistance in Transition from Homelessness and Mental Health Services to the Homeless Block Grant

The MHSH block grant program was authorized under the Stewart B. McKinney Homeless Assistance Act of 1987. This program was designed to provide funds to each State, the District of Columbia, Puerto Rico, and the U.S. territories to support services to individuals who are chronically mentally ill and homeless. In 1990, Congress enacted the Stewart B. McKinney Homeless Assistance Amendments Act, which revised certain features of the program and authorized it under a new name, the PATH formula grant program. The PATH program was implemented in FY1991. PATH is designed to provide funds to each State, the District of Columbia, Puerto Rico, and the U.S. territories to support services to individuals with severe mental illness, as well as individuals with both severe mental illness and substance use disorders, who are homeless or at risk of becoming homeless. Eligible services funded under PATH include screening and diagnostic treatment; outreach; habilitation and rehabilitation; community mental health; alcohol or drug treatment (for individuals with co-occurring mental illness and substance abuse disorders); staff training; case management; supportive

and supervisory services in residential settings; and referrals for primary health care, job training, and education.

Comprehensive Community Mental Health Services Program for Children and Their Families Program

The Comprehensive Community Mental Health Services for Children and Their Families program was authorized in 1992 in the ADAMHA Reorganization Act to provide grants to States, political subdivisions, Native American reservations, and tribal organizations for the provision of an array of community-based services organized into a system of care for children with serious emotional, behavioral, or mental disorders and their families. Funded initially at a level of $4.9 million in FY1993, the appropriation was increased in FY1994 to $35 million and to $60 million in FY1995 and FY1996. FY1997 funding has been increased to approximately $70 million. The purpose of the program is to plan, develop, and implement systems of care that are comprehensive, community-based, coordinated, family-focused, and culturally competent.

The individuals served by these systems of care are persons from birth to age 18, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV, that resulted in functional disturbances. Approximately 14 to 20 percent (8 to 13 million) of all American children experience mental and emotional disturbances. Included in this group are approximately 3.5 million youngsters (5 percent of the child and adolescent population) who have serious emotional disturbances.

The Comprehensive Community Mental Health Services for Children and Their Families program currently supports 22 grants to eligible entities. Communities are developing local systems of care, highlighting service collaboration among mental health, child welfare, education, juvenile justice, and other appropriate agencies. The program is ensuring that services that are currently underdeveloped or nonexistent in most communities, such as respite care; day treatment; therapeutic foster care; intensive home-, school-, or clinic-based services; emergency services; therapeutic case management; and diagnostic and evaluation services, are funded. Each child served through the program is receiving an individualized service plan developed with participation of the family (and where appropriate, the child). Each individualized plan designates a case manager to assist the child and family.

Protection and Advocacy Program for Individuals With Serious Mental Illness

The PAIMI Act of 1986 authorizes formula allotments to be awarded to P&A systems that have been designated by the Governor in each State to protect the rights of and advocate for individuals with disabilities. The allotments are to be used to pursue administrative, legal, and other appropriate remedies to redress complaints of abuse, neglect, and rights violations and to protect and advocate the rights of individuals with mental illness through activities to ensure the enforcement of the Constitution and Federal and State statutes.

The PAIMI programs have the authority to: (1) protect and advocate for the rights of persons with mental illness and (2) investigate reports of abuse and neglect in facilities that care for, or treat, individuals with mental illness. PAIMI programs may also address issues that arise during transportation to, admission to, or 90 days after discharge from, such facilities. Individuals eligible for services are those who have a significant mental illness or emotional impairment and who live in residential facilities. These facilities, which may be public or private, include hospitals, nursing homes, semi-independent or supervised community facilities, homeless shelters, jails, and prisons. P&As have special legal authority to access public and private facilities, meet with residents and clients, and maintain records for the purpose of conducting independent investigations of incidents of abuse and neglect.

Each P&A has a governing authority or board of directors with members who broadly represent and are knowledgeable about the needs of its clients. Also, they each have an Advisory Council to advise the P&A system on policies and priorities to be carried out in protecting and advocating the rights of individuals with

mental illness. Sixty percent of the council is composed of recipients or former recipients of mental health services or families of such persons.

Demonstration Grant Programs

The Community Partnership program, initiated in 1990, heralded a new approach for substance abuse prevention in the Nation. The program is predicated on the concept that empowered communities can martial their resources to solve their own problems, such as substance abuse, violence, HIV/AIDS, drunk driving, school failure, and delinquency. Community Partnership grants permit representatives from government, business, health, religion, academia, schools, criminal justice, and other individuals to join together to assess, design, and implement communitywide prevention efforts. More than 30,000 nonprofit organizations and businesses have become associated with the 250 partnerships that have been funded. Partnership activities have resulted in a wide variety of policy and legislative change—from those that restrict access to substances to those that bring law enforcement closer to the community. Additional partnership accomplishments are many and include such outcomes as a decline in cases of Hepatitis B linked to intravenous drug use and a decline in alcohol-related boating deaths (Gloucester Prevention Network, Maine), a decline in drug-related misdemeanors (Southeast Queens Community Partnership), and closing of drug dealing locations (Tacoma Community Partnership, Washington; and Miami Coalition for a Drug Free Community, Florida). Many CSAP partnerships have become fully established in their communities, with stable organizational structures, self-sustaining funding sources, and representation and involvement from all sectors of the community.

Additional Demonstration Programs

SAMHSA (1992-1994) and its predecessor ADAMHA (1988-1991) supported several additional demonstration programs designed to expand services and knowledge about effective delivery of substance abuse and mental health services in distinct settings and to distinct groups of individuals with addictive and mental disorders. These programs included the Capacity Expansion, Target Cities, Critical Populations, Criminal Justice, Treatment Campus, HIV/AIDS Outreach, Women and Children, and National Capital Area Demonstration, and the DC Initiatives programs funded by SAMHSA's Center for Substance Abuse Treatment; the High Risk Youth and Pregnant and Postpartum Women and Infants programs funded by SAMHSA's Center for Substance Abuse Prevention; and the Access to Community Care and Effective Services and Support, Community Support, and AIDS demonstration programs funded by SAMHSA's Center for Mental Health Services.

Appendix B:

Additional Information on HRSA Programs

Community and Migrant Health Centers

These centers provide culturally sensitive, family-oriented preventive and primary health care services. They also provide essential ancillary services such as dental, laboratory test, x-ray, and pharmacy services. In addition, many centers provide other health and community services, such as transportation, nutrition, and health education. Health center services are tailored to meet the specific needs of the communities they serve, including the needs of special population groups (for example, the homeless, HIV-positive, and substance abusers).

Approximately 625 centers across the United States and its territories provide primary health care for approximately 7.0 million persons. For FY1994, the Community Health Centers program was appropriated $603.7 million; the Migrant Health Centers program was appropriated $59.0 million. Most centers also receive funding from State and local governments, Medicaid reimbursements, and other sources.

Maternal and Child Health Block Grant

The Maternal and Child Health (MCH) block grant program is a Federal and State partnership program designed to improve the health of mothers, children, and adolescents consistent with the National Health Objectives for the year 2000. The population served by these grants are primarily low-income, disadvantaged mothers and infant children. Services provided include the diagnosis and treatment of specific diseases or conditions, nutrition, periodic screening, and immunization services for children. The program provides health services for more than 11.6 million women, infants, and children with special health care needs.

A special set-aside of the block grant funds special projects of regional and national significance (SPRANS), by providing support for research in such areas as genetic diseases and hemophilia, and training for providers of such services.

Another maternal and child health-oriented program is the Emergency Medical Services (EMS) for Children program. The objectives of this program are to enhance and expand delivery of emergency medical services to acutely ill and seriously injured children. The goal is to reduce child and youth mortality and morbidity sustained as a result of severe acute illness or trauma.

In FY1994, the MCH block grant program was appropriated $687.0 million. Of this amount, $101.4 million was set aside for SPRANS projects. The EMS for Children program was appropriated $7.5 million for FY1994.

Ryan White AIDS Services

Title XXVI, Part A, of the PHS Act authorizes grants for outpatient and ambulatory health and support services to metropolitan areas with a specified cumulative total of reported cases of AIDS or a specified per capita incidence of AIDS. Grantees are required to establish HIV health services planning councils to establish priorities for the allocation of funds within the eligible area, to develop a comprehensive plan for the organization and delivery of health services, and to assess the efficiency of the administrative mechanism in rapidly allocating funds to areas of greatest need within the eligible area.

Title XXVI of the Public Health Service Act, Part B, authorizes grants for States and territories in support of systems of health care services for people with HIV infection. The State and territories programs provide services through service delivery consortia in the localities most affected by HIV/AIDS. Services include

home- and community-based care for individuals, continuation of health insurance coverage for low-income persons, and treatments that have been determined to prolong life or prevent serious deterioration of health.

This title (Part C) also authorizes the Early Intervention Services grants, which provide assessment and health services for mothers and their children infected with the HIV virus and uninfected siblings.

In FY1994, $325.5 million was appropriated for Part A (metropolitan area grants), $183.9 million was appropriated for Part B programs (State and territory grants), and $48.0 million was appropriated for Part C (Early Intervention Services grants).

Health Care for the Homeless (HCH) Services

The HCH program provides access for homeless individuals to comprehensive, family-oriented primary care services, including immunizations and substance abuse services. Under this project grant program, all homeless individuals, including immigrants, are eligible for services. In FY1994, the HCH program was appropriated $63.0 million. During the 1994 calendar year, HCH services were provided to approximately 450,000 homeless individuals.

Health Services for Residents of Public Housing

The Health Services for Residents of Public Housing program awards grants to local communities for the delivery of comprehensive, accessible, and affordable primary care services to public housing residents. The program was established through a cooperative effort with HUD and other appropriate Federal, State, and local organizations. In FY1994, the program was appropriated $8.9 million. During calendar year 1992, 7 projects provided health care services to 18,017 individuals.

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